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Before the  
Federal Communications Commission  
Washington, D.C. 20554

In the Matter of

Rural Health Care Support Mechanism

WC Docket No. 02-60

**REPORT AND ORDER, ORDER ON RECONSIDERATION,  
AND FURTHER NOTICE OF PROPOSED RULEMAKING**

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By the Commission: Chairman Powell and Commissioners Abernathy, Copps, and Adelstein  
issuing separate statements.

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## I. INTRODUCTION

1. In this *Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking*, we modify our rules to improve the effectiveness of the rural health care support mechanism, which provides discounts to rural health care providers to access modern telecommunications for medical and health maintenance purposes. Because participation in the rural health care support mechanism has not met the Commission's initial projections, we amend our rules to improve the program, increase participation by rural health care providers, and ensure that the benefits of the program continue to be distributed in a fair and equitable manner. Specifically, we expand the scope of entities eligible to receive discounts, provide support for Internet access, and modify the way in which we calculate discounts to offer rural health care providers more flexibility. In addition, in the *Order on Reconsideration*, we deny

Mobile Satellite Ventures Subsidiary's petition for reconsideration of the 1997 *Universal Service Order*.<sup>1</sup> Lastly, in the *Further Notice of Proposed Rulemaking*, we seek comment on modifications to the definition of "rural area" for the rural health care support mechanism, whether additional modifications to our rules are appropriate to facilitate the provision of support to mobile rural health clinics for satellite services, and additional outreach efforts and measures to streamline further the application process. The actions we take today encourage the development of public/private partnerships and other creative solutions to meet the needs of rural communities and increase participation in the rural health care mechanism.

2. The actions we take today will also strengthen telemedicine and telehealth networks across the nation, help improve the quality of health care services available in rural America, and better enable rural communities to rapidly diagnose, treat, and contain possible outbreaks of disease. Moreover, enhancing access to an integrated nation-wide telecommunications network for rural health care providers will further the Commission's core responsibility to make available a rapid nation-wide network for the purpose of the national defense, particularly with the increased awareness of the possibility of biological or chemical terrorist attacks. Finally, these changes will further the Commission's efforts to improve its oversight of the operation of the program to ensure that the statutory goals of section 254 of the Telecommunications Act of 1996 are met without waste, fraud, or abuse.<sup>2</sup>

## II. BACKGROUND

3. In section 254 of the Act, Congress sought to provide rural health care providers "an affordable rate for the services necessary for the purposes of telemedicine and instruction relating to such services."<sup>3</sup> Specifically, Congress directed telecommunications carriers "[to] provide telecommunications services which are necessary for the provision of health care services in a State, including instruction relating to such services, to any public or nonprofit health care provider that serves persons who reside in rural areas in that State, at rates that are reasonably comparable to rates charged for similar services in urban areas in that State."<sup>4</sup> Congress also directed the Commission to enhance access to advanced telecommunications and information services for health care providers.<sup>5</sup>

4. The Commission implemented this statutory directive by adopting the rural health care support mechanism in the 1997 *Universal Service Order*. Specifically, the Commission concluded that telecommunications carriers must charge eligible rural health care providers a rate for each supported service that is no higher than the highest tariffed or publicly available commercial rate for a similar service in the closest city in the state with a population of 50,000

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<sup>1</sup> *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Report and Order, 12 FCC Rcd 8776 (1997) (1997 *Universal Service Order*) (subsequent history omitted).

<sup>2</sup> Pub. L. No. 104-104, 110 Stat. 56. The 1996 Act amended the Communications Act of 1934 (the Act). See 47 U.S.C. §§ 151 *et seq.*

<sup>3</sup> H.R. Conf. Rep. No. 458, 104<sup>th</sup> Cong. 2<sup>nd</sup> Sess. 133 (1996). See also Pub. L. No. 104-104, 110 Stat. 56.

<sup>4</sup> See 47 U.S.C. §§ 151 *et seq.* (adding 47 U.S.C. § 254(h)(1)(A) to the Act).

<sup>5</sup> 47 U.S.C. § 254(h)(2)(A).

or more people, taking distance charges into account.<sup>6</sup> The Commission also adopted mechanisms to provide support for limited toll-free access to an Internet service provider.<sup>7</sup> The Commission adopted an annual cap of \$400 million for universal service support for rural health care providers.<sup>8</sup> The Commission based its conclusions on analysis of the condition of the rural health care community and technology at that time.<sup>9</sup>

5. Since then, the Commission has made some changes to the rural health care support mechanism to make it more viable and to reflect technological changes.<sup>10</sup> Because only a small number of rural health care providers qualified for discounts in the original funding cycle, which covered the period from January 1, 1998 through June 30, 1999, the Commission reevaluated the structure of the rural health care universal service support mechanism in the fall of 1999.<sup>11</sup> At that time, the Commission: (1) simplified the urban/rural rate calculation; (2) eliminated the per-location discount limit; (3) encouraged participation in consortia; and (4) re-allocated billing and collection expenses by the number of participants in the rural health care universal service support mechanism.<sup>12</sup> The Commission also determined that the definition of "health care provider" does not include nursing homes, hospices, other long-term care facilities, or emergency medical service facilities.<sup>13</sup> The Commission also decided not to further clarify the definition of "health care provider" or to provide additional support for long distance

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<sup>6</sup> 1997 *Universal Service Order*, 12 FCC Rcd at 9093, para. 608.

<sup>7</sup> *Id.*

<sup>8</sup> 47 C.F.R. § 54.623; 1997 *Universal Service Order*, 12 FCC Rcd at 9141, para. 705. The Commission subsequently limited support for the first funding cycle to \$100 million. See *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Fifth Order on Reconsideration and Fourth Report and Order in CC Docket No. 96-45, 13 FCC Rcd 14915, 14928-33 (1998).

<sup>9</sup> See 1997 *Universal Service Order*, 12 FCC Rcd at 9094 n.1556 (based upon material supplied by the Advisory Committee on Telecommunications and Health Care (comprised of experts in the fields of health care, telecommunications, and telemedicine) and the Federal-State Joint Board on Universal Service (referring to FCC Advisory Committee on Telecommunications and Health Care, Findings and Recommendations, October 15, 1996, and *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Recommended Decision, 12 FCC Rcd 87 (1996) (*Recommended Decision*)).

<sup>10</sup> In September 1999, the Commission adopted the *Fourteenth Order on Reconsideration*, in which the Commission determined that all telecommunications carriers that provide supported services to eligible health care providers under section 254(h)(1)(A) are entitled to have a credit against their universal service contribution obligation equal to the difference between the lower, urban rate they offer eligible health care providers for supported telecommunications services and the higher, rural rates that would normally be charged to these customers. *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Fourteenth Order on Reconsideration, 14 FCC Rcd 20106 (1999) (*Fourteenth Order on Reconsideration*).

<sup>11</sup> *Changes to the Board of Directors of the National Exchange Carrier Association, Inc.*, *Federal-State Joint Board on Universal Service*, CC Docket Nos. 97-21 and 96-45, Sixth Order on Reconsideration in CC Docket No. 97-21 and Fifteenth Order on Reconsideration in CC Docket No. 96-45, 14 FCC Rcd 18756, 18760-61, para. 7 (1999) (*Fifteenth Order on Reconsideration*) (noting that there were 2,500 initial applications, and only a small fraction made it through the first funding cycle).

<sup>12</sup> *Fifteenth Order on Reconsideration*, 14 FCC Rcd at 18762, para. 9.

<sup>13</sup> *Id.* at 18786, para. 48.

telecommunications service.<sup>14</sup>

6. The rural health care community and participating service providers now have six years of experience with the rural health care support mechanism.<sup>15</sup> Over this period, the rural health care mechanism has provided support to rural health care providers in 45 states and the U.S. Virgin Islands, to enable them to obtain access to modern telecommunications services for medical and health maintenance purposes.<sup>16</sup> Such support has facilitated the delivery of medical services to people who would otherwise have to wait for care, go without it, or take long and expensive journeys across difficult terrain to find help. Telemedicine allows rural health care providers in isolated areas to consult with specialists in an effective manner and treat patients locally, rather than waiting for scheduled visits or trying to describe patient conditions orally to specialists with the requisite degree of accuracy and completeness.

7. In some instances, telemedicine can save lives. For example, a video teleconference link allowed a surgeon in Anchorage to provide real-time guidance to a doctor in an isolated village in Alaska while he performed life-saving emergency surgery to stem bleeding for a patient diagnosed with an ectopic pregnancy.<sup>17</sup> The emergency surgery was necessary, because the patient could not be airlifted to Anchorage due to fog. In Virginia, telemedicine links, which transported high-quality ultrasound pictures, allowed a neonatal cardiologist to remotely diagnose an infant located in a rural hospital with a descending aorta.<sup>18</sup> The doctor was able to prescribe medication, which provided additional time to transport the infant to a specialty hospital for open heart surgery.

8. In 2002, the Commission issued a *Notice of Proposed Rulemaking (NPRM)* to review the rural health care universal service support mechanism.<sup>19</sup> The Commission was prompted to act by a number of factors. First, the mechanism is greatly underutilized. Only 1,194 rural health care providers out of nearly 8,300 potential applicants received support in Funding Year 2001.<sup>20</sup> Indeed, notwithstanding the annual funding cap of \$400 million, the

<sup>14</sup> *Id.* at 18762, para. 9.

<sup>15</sup> Funding Year 2003 is the sixth year of the program.

<sup>16</sup> Second Annual Telehealth Leadership Conference, Washington, DC, June 2, 2003, Session III "Universal Service Fund Update," available at <http://www.americantelemed.org/conf/annualmeet.htm> (retrieved November 13, 2003) (The following States are not currently receiving support: CT, DE, MD, RI. Two states that do not have rural areas, DC and NJ, are also not currently receiving support.).

<sup>17</sup> Nichole Tsong, *Live Video Gives Kotzebue Doctor a Surgeon's Eye*, Anchorage Daily News, September 4, 2003, at A1.

<sup>18</sup> Steve Thompson, *No Mountain Too High*, Rural Cooperatives May/June 2003, at 22.

<sup>19</sup> *Rural Health Care Support Mechanism*, Notice of Proposed Rulemaking, WC Docket No. 02-60, 17 FCC Rcd 7806 (2002) (*NPRM*). We received seventy-five comments, fourteen reply comments, and six *ex partes* in response to the *NPRM*. Appendix B provides the full and abbreviated names of the parties. See Appendix B.

<sup>20</sup> See USAC Rural Health Care Division All Stats-6-30-03 (FY 2001) (Note that results for Funding Year 2002 that closes on October 8, 2003, are not yet available); Universal Service Administrative Company Report of Health Care Providers Eligible for Support Under the Rural Health Care Universal Service Support Mechanism, at 4 (April 5, 2001) (USAC Research Results Report) (stating there were approximately 8,297 health care providers in the United States as of September 2000).

Rural Health Care Division (RHCD) of the Universal Service Administrative Company (USAC or the Administrator) disbursed only \$30.25 million in total discounts for the first five years of operation of the universal service support mechanism.<sup>21</sup> Reexamining certain aspects of our rules and instituting other streamlining changes should greatly increase the number of rural health care providers that could benefit from the mechanism, without modifying the existing funding cap.

9. Second, changes in telecommunications technology and its use by the medical community warrant a re-evaluation of some aspects of the mechanism. For instance, Internet points of presence now exist throughout the country's telecommunications network.<sup>22</sup> More sophisticated medical imaging technology is available today than existed in 1997, which requires high speed access to display images used for diagnostic purposes.<sup>23</sup>

10. Finally, in addition to section 254, our core statutory mandate, as set out in 47 U.S.C. § 151, states in relevant part, that we should make "available, so far as possible, to all the people of the United States ... a rapid, efficient, Nation-wide ... wire and radio communications service with adequate facilities at reasonable charges, for the purpose of the national defense, [and] for the purpose of promoting safety of life and property through the use of wire and radio communication."<sup>24</sup> Consistent with the statutory mandate, further utilization of the rural health care universal service support mechanism may benefit the development of a broader and more fully integrated network of health care providers across our nation. In the aftermath of recent national events, the importance of such a network to national security and public safety is significant. Improvements to the rural health care support mechanism also should better enable rural communities to rapidly diagnose, treat, and contain possible outbreaks of disease, while helping to provide better health care generally in rural areas by facilitating broader and faster transfer of critical information. In addition to crisis response, telemedicine and telehealth could play a critical role in informing rural health care providers about emerging

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<sup>21</sup> See Universal Service Administrative Company 2002 Annual Report. The RHCD administers the rural health care support mechanism under the direction of the Federal Communications Commission. See *Changes to the Board of Directors of the National Exchange Carrier Association, Inc., Federal-State Joint Board on Universal Service*, CC Docket Nos. 97-21 and 96-45, Third Report and Order in CC Docket No. 97-21 and Fourth Order on Reconsideration in CC Docket No. 97-21 and Eighth Order on Reconsideration in CC Docket No. 96-45, 13 FCC Rcd 25058 (1998).

<sup>22</sup> See, e.g., NTCA Members Internet/Broadband Survey Report, National Telephone Cooperative Association, at 17 (November 2000), available at [http://ntca.netstrategies.com/content\\_documents/broadbandstudy.pdf](http://ntca.netstrategies.com/content_documents/broadbandstudy.pdf) (retrieved November 13, 2003) (referencing a survey of members of the National Telephone Cooperative Association indicating that about 97% of respondents reported local dial-up telephone access within their service areas). See also Ronald A. Wirtz, *The Need For Speed*, Fedgazetts, November 1, 2001, available at <http://minneapolisfed.org/pubs/fedgaz/01-11/speed.cfm> (retrieved November 13, 2003) ("Early on, access to the Internet often meant a long-distance call to an ISP, which had limited points-of-presence...a variety of sources suggest that [the ISP industry] has grown from several hundred five or six years ago to some 3,500 by 1998, to about 7,000 today, each of which brings with it at least one additional POP to the system, and usually many more.").

<sup>23</sup> See, e.g., David Charles, M.D., *What's Next: Skyway to Health*, Telephony, April 1, 2002, at 40.

<sup>24</sup> 47 U.S.C. § 151.

threats and improving preparedness.<sup>25</sup>

### III. REPORT AND ORDER

#### A. Eligible Health Care Provider

11. *Background.* Section 254(h)(1)(A) requires telecommunications carriers to provide discounted telecommunications services to *any public or non-profit health care provider* that serves rural areas in a State.<sup>26</sup> Section 254(h)(7)(B) defines the term “health care provider” as:

- (i) post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools;
- (ii) community health centers or health centers providing health care to migrants;
- (iii) local health departments or agencies;
- (iv) community mental health centers;
- (v) not-for-profit hospitals;
- (vi) rural health clinics; and
- (vii) consortia of health care providers consisting of one or more entities described in clause (i) through (vi).<sup>27</sup>

In the 1997 *Universal Service Order*, the Commission declined to expand the definition of “health care provider” beyond these seven statutory categories.<sup>28</sup> The Commission concluded that if Congress had intended other entities to qualify as health care providers, it would have explicitly included them within the statute.<sup>29</sup> Accordingly, on reconsideration, the Commission rejected arguments to expand the definition of “health care provider” to include long-term care facilities, such as nursing homes and hospices, and emergency medical service facilities.<sup>30</sup> The Commission did not address what would constitute a “public” health care provider.

12. Subsequently, in the *NPRM*, the Commission sought comment on whether it should revisit its prior interpretations of the terms “health care provider” and “rural health clinic” to expand the number of entities eligible to receive discounted telecommunications services.<sup>31</sup> Specifically, the Commission invited comment on whether to expand the definition to include rural health care providers that provide ineligible services, even on a primary basis, but also

<sup>25</sup> See, e.g., *HHS Bioterrorism Preparedness: CDC's Role in Public Health Protection*, Statement by Tommy G. Thompson before the Commission on Energy and Commerce, U.S. House of Representatives (November 15, 2001) (emphasizing the importance of public health communications infrastructure to facilitate information sharing concerning potential bioterrorism agents); 147 Cong. Rec. H10440 (December 19, 2001) (statement of Rep. Bereuter) (noting importance of telemedicine in combating bioterrorism).

<sup>26</sup> 47 U.S.C. § 254(h)(1)(A) (emphasis added).

<sup>27</sup> 47 U.S.C. § 254(h)(7)(B).

<sup>28</sup> 1997 *Universal Service Order*, 12 FCC Rcd at 9118-19, paras. 655-56.

<sup>29</sup> *Id.*

<sup>30</sup> *Fifteenth Order on Reconsideration*, 14 FCC Rcd at 18786, para. 48.

<sup>31</sup> *NPRM*, 17 FCC Rcd at 7813, para. 16.

serve as a rural health clinic or in another capacity that would qualify it as an eligible “health care provider” under the statute.<sup>32</sup> The Commission explained that such multipurpose providers might play a vital role in responding to public health crises affecting communities located in remote regions of our country.<sup>33</sup> The Commission also sought comment on whether it would be practical to prorate discounts to the extent these entities operate as eligible health care providers.<sup>34</sup>

13. *Discussion.* We now further define the statutory term “public health care provider.” We conclude that dedicated emergency departments of rural for-profit hospitals that participate in Medicare should be deemed “public” health care providers eligible to receive prorated rural health care support.<sup>35</sup> We agree with commenters that this clarification is consistent with congressional intent and is necessary to give meaning to the term “public” health care provider under the rural health care program.<sup>36</sup> Dedicated emergency departments in for-profit hospitals, including the emergency departments of critical access hospitals,<sup>37</sup> are required, pursuant to the

<sup>32</sup> *Id.*

<sup>33</sup> *Id.*

<sup>34</sup> *Id.* at para. 17.

<sup>35</sup> 47 C.F.R. § 54.601(a)(1) as adopted herein. Previously, these providers were ineligible for support because they are associated with for-profit hospitals. See 47 U.S.C. § 254(h)(7)(B). Dedicated emergency departments are defined under health care regulations as any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:

- (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;
- (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
- (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during the calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

42 C.F.R. § 489.24.

<sup>36</sup> See, e.g., Letter to Marlene Dortch, Secretary, Federal Communications Commission, from Karen S. Rheuban, MD, Medical Director, and Eugene Sullivan, MS, Director, filed on behalf of the Office of Telemedicine, University of Virginia Health System, dated August 15, 2003 (“UVA *Ex Parte*”); Kansas DHE Comments at 1; Kansas Hosp. Assoc. Comments at 1; Kingston eHealth Comments at 4; Minn. Ambulance Assoc. Comments at 1; NRHA Comments 1; Nebraska Office of Rural Health Comments 1.

<sup>37</sup> Critical access hospitals were created under the Medicare Rural Hospital Flexibility Program, authorized by Congress under section 4201 of the Balanced Budget Act of 1997. Balanced Budget Act of 1997, Pub. L. 105-33, § 4201, 111 Stat. 251, 712-31, 756-59 (1997). In essence, critical access hospitals are limited-service rural non- or for-profit hospitals that provide outpatient and short-term inpatient hospital care on an urgent or emergency basis, then release patients or transfer them to a full-service hospital. To date, over 100 critical access hospitals have been designated by the state as necessary providers of medical services. See National Conference of State Legislatures Rural Health Brief – Ensuring the Survival of Critical Access Hospitals: The New Medicare Rural Hospital Flexibility Program and the Important Role for States (2000), available at <http://www.ruralhealth.hrsa.gov/pub/IssueBrief1.htm> (retrieved September 4, 2003).

(continued....)



Emergency Medical Treatment and Labor Act (EMTALA),<sup>38</sup> to provide medical screening examinations to all patients who present themselves and to stabilize or arrange for appropriate transfer of those patients with emergency conditions.<sup>39</sup> Thus, such providers are “public” in nature by virtue of the persons they are required, pursuant to EMTALA, to examine and/or treat for emergency medical conditions.

14. Moreover, we now determine that dedicated emergency departments in for-profit rural hospitals constitute “rural health clinics.”<sup>40</sup> As UVA notes, in most communities, emergency departments are the only ambulatory care entities that serve the public on a 24-hour a day, 7-day a week basis.<sup>41</sup> In many instances, emergency departments of rural for-profit hospitals and critical access hospitals are the only health care providers in rural areas serving the medical needs of the community. Dedicated emergency departments typically provide the types of medical services often provided in traditional health clinics. Therefore, we find that dedicated emergency departments in rural for-profit hospitals should be eligible to receive prorated discounts as “public” “health providers,” and more specifically as “public” “rural health clinics.” It is necessary to clarify the definition of “rural health clinic” in this way to promote timely access to acute specialty healthcare services, chronic disease management programs and other preventive services essential to public health and safety. These entities are generally the initial point of entry into the healthcare system for any person suffering the consequences of a severe catastrophe or accident and constitute a vital segment of the health care community, particularly in the event of a national public health emergency.

15. Additionally, as suggested by several commenters,<sup>42</sup> given the realities of rural health care providers in offering quality health care services in rural areas, we clarify the entities listed in section 254(h)(7)(B) that qualify as rural “health care providers.” We conclude that entities listed in section 254(h)(7)(B) include non-profit entities that function as one of the listed entities on a part-time basis.<sup>43</sup> Pursuant to this modification, non-profit entities that provide ineligible services, even on a primary basis, would be able to receive prorated support

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<sup>38</sup> EMTALA was passed as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), which was signed into law in 1986. See Consolidated Omnibus Budget Reconciliation Act of 1985, Pub.L. 99-272, § 9121, 100 Stat. 82 (1986).

<sup>39</sup> See 42 U.S.C. § 1395dd. Specifically, section (c)(1) of the Emergency Medical Treatment and Labor Act (EMTALA) states that “if an individual at a hospital has an emergency medical condition which has not been stabilized...the hospital may not transfer the individual unless--(A)(ii) a physician has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual.” 42 U.S.C. § 1395dd(c)(1). These provisions are applicable to both non-profit and for-profit hospitals. See 42 U.S.C. § 1395dd.

<sup>40</sup> 47 U.S.C. § 254(h)(7)(B)(vi).

<sup>41</sup> See UVA *Ex Parte* at 3.

<sup>42</sup> See, e.g., Institute of Rural Health Comments at 5; UVA Comments at 7-10.

<sup>43</sup> 47 U.S.C. § 254(h)(7)(B).

commensurate with their provision of eligible rural health care services.<sup>44</sup> For example, if a doctor operated a rural health clinic on a non-profit basis in a rural community one day per week or during evenings in the local community center, that community center would be able to receive prorated support, because it serves as a “rural health clinic” on a part-time basis.<sup>45</sup> Similarly, if a non-profit community mental health center also operated as a for-profit pharmacy, that center would also be able to receive prorated support as a part-time “community mental health center.”<sup>46</sup> Our goal in implementing this proposal is two-fold – to encourage the development of public/private partnerships and other creative solutions to meet the needs of rural communities, and to increase participation in the rural health care support mechanism.

16. We decline to expand the definition of health care provider to include nursing homes, hospices, and other long-term care facilities.<sup>47</sup> Congress specifically listed seven categories of entities eligible for support under this program in section 254(h)(7)(B).<sup>48</sup> Given this specific listing, we find that if Congress had intended to include nursing homes, hospices, and other long-term care facilities as health care providers, it would have explicitly done so in the statute.<sup>49</sup> The Commission is not authorized to amend the statute to add categories to the definition, as suggested by commenters. Thus, we affirm the Commission’s previous decision that nursing homes, hospices, and other long-term care facilities are ineligible for support, whether operated on a for-profit or non-profit basis.<sup>50</sup> However, because Congress did specifically list seven categories of entities qualifying as health care providers, the Commission may clarify the types of entities that fit within those seven categories. Therefore, consistent with our clarification that entities that serve as a non-profit rural health care clinic on a part-time basis are “health care providers,” part-time non-profit rural health care clinics are eligible for prorated support, even when associated with a nursing home, hospice, or other long-term care facility.<sup>51</sup>

17. In addition, at this time, we decline to expand the definition of rural health care provider to include any rural, non-profit health care entity with a certified Medicare and/or Medicare provider number as proposed by commenters.<sup>52</sup> The record lacks sufficient

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<sup>44</sup> 47 C.F.R. § 54.601(d) as adopted herein.

<sup>45</sup> 47 U.S.C. § 254(h)(7)(B)(vi); *see infra* paras. 49-51 for discussion on allocating eligible and ineligible use.

<sup>46</sup> *Id.*

<sup>47</sup> *See, e.g.,* Avera Comments at 1; Cortland Co. Health Dept. Comments at 1; Univ. of Arizona Health Sciences Comments at 1; Arkansas DIS Reply Comments at 1.

<sup>48</sup> 47 U.S.C. § 254(h)(7)(B).

<sup>49</sup> 47 U.S.C. § 254(h)(7)(B).

<sup>50</sup> *Fifteenth Order on Reconsideration*, 14 FCC Rcd at 18786, para. 48.

<sup>51</sup> We thus reverse in part the Commission’s decision that non-profit nursing homes, hospices, and long-term care facilities are 100% ineligible. To the extent such entities function as rural health clinics, even on a part-time basis, they would be eligible for prorated support as described above. *See supra* para. 14.

<sup>52</sup> *See* ATA Comments at 5; CTTC Comments at 4; Center for Telemedicine Law Comments at 5; Institute of Rural Health Comments at 5; MGHS Reply Comments at 6; Nevada State Office Comments at 4; Northwest (continued....)

information to identify the types of entities that would become eligible under this proposal, as Medicare/Medicaid supports a wide range of services, drugs, and products. We are concerned that by including such entities within the definition of "health care provider" we may exceed our statutory authority. Moreover, with the information in the record we are unable to determine the potential impact on the demand for support.

## B. Eligible Services

### 1. Internet Access

18. *Background.* "Information services" are defined in the Act as "the offering of a capability for generating, acquiring, storing, transforming, processing, retrieving, utilizing, or making available information via telecommunications, and includes electronic publishing, but does not include any use of any such capability for the management, control, or operation of a telecommunications system or the management of a telecommunications service."<sup>53</sup> Internet access is an information service that allows consumers, including rural health care providers, to access the Internet.<sup>54</sup> More specifically, Internet access allows users to "alter the format of information through computer processing applications such as protocol conversion and interaction with stored data."<sup>55</sup>

19. Section 254(h)(2)(A) provides that the Commission "shall establish competitively neutral rules to enhance, to the extent technically feasible and economically reasonable, access to advanced telecommunications and information services for all public and non-profit elementary and secondary school classrooms, health care providers, and libraries . . . ."<sup>56</sup> Accordingly, the Act contemplates actions to enhance access to information services, such as Internet access, for rural health care providers.<sup>57</sup>

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Telehealth Comments at 3; Poudre Valley Health Comments at 1; Univ. of Tennessee Health Science Comments at 3.

<sup>53</sup> 47 U.S.C. § 153(20).

<sup>54</sup> Fundamentally, the Internet is a global, packet switched network that enables interconnection between networks using Internet Protocol (IP). The Supreme Court has described the Internet as "an international network of interconnected computers." *Reno v. ACLU*, 521 U.S. 844, 849-50 (1997). See also Kevin Werbach, *Digital Tornado: The Internet and Telecommunications Policy*, Office of Plans and Policy Working Paper Series 29, 15 (1997).

<sup>55</sup> *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Report to Congress, 13 FCC Rcd 11501, 11516-17, para. 33 (1998) (*Report to Congress*) (citations and internal quotations omitted). See also *Appropriate Framework for Broadband Access to the Internet over Wireline Facilities, Universal Service Obligations of Broadband Providers, Computer III Further Remand Proceedings: Bell Operating Company Provision of Enhanced Services; 1998 Biennial Regulatory Review – Review of Computer III and ONA Safeguards and Requirements*, CC Docket Nos. 02-33, 95-20, 98-10, Notice of Proposed Rulemaking, 17 FCC Rcd 3019 nn.16-17, 27, 38 (2002) (*Wireline Broadband Internet Access NPRM*).

<sup>56</sup> 47 U.S.C. § 254(h)(2)(A).

<sup>57</sup> See *Texas Office of Public Utility Counsel*, 183 F.3d at 443-44 (affirming the Commission's authority under section 254(h)(2)(A) to provide support to non-telecommunications carriers in their provision of Internet access and internal connections). See also *1997 Universal Service Order*, 12 FCC Rcd at 9107, para. 630.

20. In the *1997 Universal Service Order*, the Commission concluded that section 254(h)(2)(A) authorizes a universal service support mechanism to enhance access to information services, as long as the mechanism is competitively neutral, technically feasible, and economically reasonable.<sup>58</sup> The Commission declined, however, to provide support to rural health care providers for Internet access at that time due to the limited record and the complexity of the proposals.<sup>59</sup> Pursuant to section 254(h)(2)(A), the Commission did, however, provide limited support for toll charges incurred by all health care providers that could not obtain toll-free access to an ISP.<sup>60</sup>

21. In the *NPRM*, the Commission sought comment on whether to provide support for Internet access provided to rural health care providers.<sup>61</sup> The Commission also sought comment on the range of health care services and information that is available via the Internet, on the ability of the Internet to provide to rural communities the types of health care information that are available in urban areas, and, in general, on how health care providers can make use of the Internet to provide better health-related services.<sup>62</sup> Finally, the Commission sought comment on whether demand for Internet access would likely increase total program demand above the \$400 million cap and how increased demand would affect the operation of the rural health care mechanism.<sup>63</sup>

22. *Discussion.* Given the rapid development of the Internet's capacities, the proliferation of applications available on the Internet, and the increase in the number of Internet users since the *1997 Universal Service Order* was issued, we believe that it is now appropriate to provide funding for Internet access to rural health care providers.<sup>64</sup> In particular, we conclude that support equal to twenty-five percent of the monthly cost for any form of Internet access reasonably related to the health care needs of the facility should be provided to rural health care providers.<sup>65</sup> The definition for Internet access that we adopt here is intended to provide rural health care providers considerable flexibility to utilize the resources available over the Internet that will assist them in fulfilling their health care needs.

23. We agree with commenters that the Internet can serve as an invaluable resource, by

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<sup>58</sup> *1997 Universal Service Order*, 12 FCC Rcd at 9109, para. 634. Indeed, the Commission specifically rejected the notion "that support for non-telecommunications services is . . . barred under . . . section 254(h)(2)." *Id.* See also 47 U.S.C. § 154(i).

<sup>59</sup> *1997 Universal Service Order*, 12 FCC Rcd at 9106-07, 9161, paras. 629-30, 749.

<sup>60</sup> *1997 Universal Service Order*, 12 FCC Rcd at 9107-08, para. 631; 47 U.S.C. § 254(h)(2)(A). The support was limited to the lesser of \$180.00 or 30 hours of usage per month, if a rural health care provider could not reach an ISP without incurring toll charges. *1997 Universal Service Order*, 12 FCC Rcd at 9159, para. 745.

<sup>61</sup> *NPRM*, 17 FCC Rcd at 7815, para. 20.

<sup>62</sup> *Id.* at 7816, para. 22.

<sup>63</sup> *Id.* at 7816, para. 25.

<sup>64</sup> See generally *1997 Universal Service Order*.

<sup>65</sup> 47 C.F.R. §§ 54.601(c)(2)(ii), 54.621(a) as adopted herein.

providing on-line courses in health education,<sup>66</sup> medical research,<sup>67</sup> follow-up care,<sup>68</sup> regulatory information such as compliance with the Health Insurance Portability and Accountability Act of 1996,<sup>69</sup> video conferencing,<sup>70</sup> web-based electronic benefit claim systems including on-line billing,<sup>71</sup> and other crucial business functions.<sup>72</sup> The incredible potential of the Internet to provide access to such a breadth of medical information may also help reduce isolation in rural communities.<sup>73</sup> In light of the development of medical applications for the Internet since 1997, we conclude that encouraging access to this information service will improve the level of care available in rural areas.

24. Furthermore, health care information shared over the Internet may enable rural health care providers to diagnose, treat, and contain possible outbreaks of disease or respond to health emergencies. We agree with commenters that Internet access provides a vital link to information and instantaneous communications in times of natural disasters and public health emergencies.<sup>74</sup> National connectivity of telehealth and telemedicine networks could also promote the national defense by serving as vehicles for rapid, secure communications in times of emergency,<sup>75</sup> due to outbreaks of disease or biological and chemical attacks.<sup>76</sup>

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<sup>66</sup> See Alaska Comments at 2; Alliance Comments at 1; Avera Comments at 2.

<sup>67</sup> See GCI Comments at 6-7.

<sup>68</sup> See Healthcare Anywhere Reply Comments at 4-9 ("Health care providers can use the Internet to receive immediate results of screenings for patients that is crucial to follow-up care. Patient compliance with follow-up care is more likely if a patient gets the results during his or her visit, gets advice on what to do next, and gets the opportunity to ask questions about his or her condition. A rural patient may need immediate results more than an urban patient because a rural patient is less likely to have a telephone for receiving results and setting up follow-up appointments.").

<sup>69</sup> See Alliance Comments 5-6; David Bolt, Lewis Co. Primary Care Center, email 8/22/03; Kansas DHE Comments at 1; Kansas Hosp. Assoc. Comments at 1; *see also* Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 2021-31.

<sup>70</sup> See Washington Rural Comments at 1-2.

<sup>71</sup> See Shannon Clark, Ashley County Medical Center, email 8/18/03; Kansas DHE Comments at 1; Kansas Hosp. Assoc. at 1.

<sup>72</sup> See Kansas DHE Comments at 1; Kansas Hosp. Assoc. Comments at 1. "[A]nyone with access to the Internet may take advantage of a wide variety of communication and information retrieval methods...[such as] electronic mail (e-mail), automatic mailing list services ('mail exploders,' sometimes referred to as 'listservs'), 'newsgroups,' 'chat rooms,' and the 'World Wide Web.' All of these methods can be used to transmit text; most can transmit sound, pictures, and moving video images. Taken together, these tools constitute a unique medium -- known to its users as 'cyberspace' -- located in no particular geographical location but available to anyone, anywhere in the world, with access to the Internet." *Reno v. ACLU*, 521 U.S. at 851.

<sup>73</sup> See *NPRM*, 17 FCC Rcd at 7816, para. 22.

<sup>74</sup> See Adams Co. Health Dept. Comments at 2; Alliance Comments at 1-2; Cortland Co. Health Dept. Comments at 1; Lane Co. Health Dept. Comments at 2; NACCHO Comments at 1; NRHA Comments at 2; WGA Comments at 3.

<sup>75</sup> See Univ. of Arizona Health Sciences Comments at 2; Illinois Center for Rural Health Comments at 3; Kingston eHealth Comments 2, 4; Madden Comments at 2; NM Health Resources Comments at 3; NOSORH Comments at (continued....)

25. Accordingly, for purposes of the rural health care support mechanism only, we define “eligible Internet access” as “an information service that enables rural health care providers to post their own data, interact with stored data, generate new data, or communicate over the World Wide Web.”<sup>77</sup> Eligible Internet access provides access to the world-wide information resource of the Internet, and includes all features typically provided by Internet service providers to provide adequate functionality and performance. To qualify as Internet access under the definition we adopt today for the rural health care support mechanism, transmissions must traverse the Internet in some fashion. Internet access may provide transport of digital communications using any Internet-based protocols, including encapsulation of data, video, or voice.

26. We specifically decline to adopt the definition of Internet access currently used in the schools and libraries support mechanism. Under those rules, Internet access includes:

- (2) The transmission of information as part of a gateway to an information service, when that transmission does not involve the generation or alteration of the content of information, but may include data transmission, address translation, protocol conversion, billing management, introductory informational content, and navigational systems that enable users to access information services, and that do not affect the presentation of information to users[.]

47 C.F.R. § 54.5.

This definition thus specifically precludes support for features that provide the capability to generate or alter the content of information.<sup>78</sup> We believe adopting such a limitation for the rural health care program would significantly undercut the utility of providing support for Internet access to rural health care providers, because the ability to alter and interact with information over the Internet is precisely the feature that could facilitate improved medical care in rural areas. Under the rural health care support mechanism, we will provide support for Internet access, as long as it is reasonably related to the health care needs of the facility, and it is the most cost-effective method of meeting those needs.<sup>79</sup> We will not provide support, however, for the

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3; Tri-County Memorial Hosp. Comments at 2-3. See also The Telemedicine Response to Homeland Safety and Security: Developing a National Network for Rapid and Effective Response for Emergency Medical Care (2001), available at <http://www.americantelemed.org/news/homelandsecurity3.3.htm> (retrieved November 13, 2003) (ATA’s proposal regarding the use of telemedicine in support of homeland security).

<sup>76</sup> See Alliance Comments 5-6; FRC Reply Comments at 13; Kingston eHealth Comments 2, 4; Madden Comments at 2; Minn. Ambulance Assoc. Comments at 2; NRHA Comments at 2; Nevada State Office Comments at 6; NM Health Resources Comments at 3; NOSORH Comments at 3; Tri-County Memorial Hosp. Comments at 3.

<sup>77</sup> 47 C.F.R. § 54.601(c)(2)(i) as adopted herein.

<sup>78</sup> To implement this rule in the schools and libraries program, the Administrator utilizes cost allocation to provide partial funding to Internet access service that contains both eligible and ineligible features. If, however, the ineligible functionality is strictly ancillary to the principle use of the Internet access service, the full price of the service is eligible for discount. See Cost Allocation for Products and Services that Contain Eligible and Ineligible Components (2002), available at <http://www.sl.universalservice.org/reference/costallocationguide.asp> (retrieved November 13, 2003).

<sup>79</sup> See *supra* para. 22, *infra* para. 28.

purchase of internal connections, computer equipment or other telecommunications equipment, even when used to access the Internet, because such items are not information services.

27. We conclude that a flat discount percentage of twenty-five percent off the cost of monthly Internet access will assist health care providers seeking to purchase Internet access, while also providing incentives for rural health care providers to make prudent economic decisions concerning their telemedical needs.<sup>80</sup> We agree with commenters that a flat discount, analogous to the operation of the schools and libraries support mechanism, will lead to greater predictability and fairness among health care providers.<sup>81</sup> A flat discount is consistent with section 254(b)(5), which requires “a specific, sufficient, and predictable mechanism . . . because it limits the amount of support that each health care provider may receive per month to a reasonable level.”<sup>82</sup> A flat discount is also easy to administer. Although it is difficult to estimate the impact of providing support for Internet access service due to the wide range of costs between and among the various types of Internet access services,<sup>83</sup> we agree with commenters’ projections that our actions today regarding Internet access are unlikely to result in program demand in excess of the cap.<sup>84</sup> We act conservatively by choosing a twenty-five

<sup>80</sup> Rural health care providers can use this discount towards the cost of monthly charges for information services only. *See supra* para. 18 (defining “information services”). Support for telecommunications services is not included under this discount. The Act defines “telecommunications service” as “the offering of telecommunications for a fee directly to the public, or to such classes of users as to be effectively available directly to the public, regardless of the facilities used.” 47 U.S.C. § 153(46).

<sup>81</sup> *See* Alaska Comments at 3; Avera Comments at 2; Florida PSC Comments at 6; Kingston eHealth Comments at 7.

<sup>82</sup> 1997 *Universal Service Order*, 12 FCC Rcd at 9159-60, para. 746; 47 U.S.C. § 254(b)(5).

<sup>83</sup> Commenters state that the monthly cost of Internet access in rural areas ranges from \$21.95 to \$800 for DSL, \$45 to \$400 for cable modem, \$40 to \$300 for wireless, \$30 to \$13,000 for satellite, \$200 to \$1046 for T-1, and \$9.95-\$26.95 for dial-up. *See* Jason Wulf, Avera Health, email 8/18/03 (\$21.95/month for DSL); Andy Adams, Murray Hospital, email 8/19/03 (\$60/month for DSL); Cherri Colliton, Perham Memorial Hospital and Home, Perham, MN, email 8/22/03 (\$200-800/month for DSL); Andy Adams, Murray Hospital, email 8/19/03 (\$45/month for cable modem); Karen Thuli, Upland Hills Health, email 8/19/03 (\$140/month for cable modem); Robert Shwajlyk, Nathan Littauer Hospital, Gloversville, NY, email 8/18/03 (\$399.25/month for cable modem); Stephanie Burnfin, Wright Memorial Hospital, email 8/19/03 (\$40/month for wireless); Jason Wulf, Avera Health, email 8/18/03 (\$44.95/month for wireless); Bill Brennan, Saint Francis Medical Center, Grand Island, NE, email 8/19/03 (\$250-300/month for wireless); Nancy Erickson, Kossuth Regional Health Center, Algona, IA, email 8/18/03 (\$30-44/month for satellite); Larry Pergerson, Scotland Health, email 8/18/03 (\$110/month for satellite); Val Warzewick, Yukon-Kuskokwim Health Corporation, Bethel, Alaska, email 8/19/03 (\$13,000/month for satellite); Karen Thuli, Upland Hills Health, email 8/19/03 (\$200/month for T-1); Lee Benson, Faith Regional Health Services, email 8/18/03 (\$900/month for T-1); Rick Tighe, County Hospital, Atlantic, Iowa, email 8/18/03 (\$1046/month for T-1); Chris Gillespie, Dickinson County, email 8/18/03 (\$9.95/month for dial-up); Rick Tighe, County Hospital, Atlantic, Iowa, email 8/18/03 (\$19.95/month for dial-up); Jerry Clayton, Kodiak, AK, email 8/18/03 (\$26.95/month for dial-up).

<sup>84</sup> *See* Adams Co. Health Dept. Comments at 2; Alliance Comments at 6; Cortland Co. Health Dept. Comments at 2; Lane Co. Health Dept. Comments at 2; NACCHO Comments at 2; NRHA Comments at 2; UVA Comments at 15; Verizon Comments at 4. For example, some commenters projected that assuming 10,000 rural health care providers took advantage of support for Internet access at a rate of approximately \$100 per month, the annual expenditure for Internet access would be \$12 million. *See* Cortland Co. Health Dept. Comments at 2; Lane Co. Health Dept. Comments at 2; NACCHO Comments at 2; NRHA Comments at 2. Assuming, *arguendo*, that all 8,300 eligible providers were to request funding under this mechanism, on a pro-rata basis, that would be roughly (continued....)

percent flat discount initially because it will provide an incentive for rural health care providers to choose a level of service appropriate to their needs, will provide more certainty that demand for Internet access support will not exceed the annual funding cap, and will deter wasteful expenditures. Furthermore, we find that a twenty-five percent discount is reasonable because provision of support to health care providers under the rural health care support mechanism is not contingent on economic need, similar to the twenty-five percent discount provided to the least disadvantaged rural schools and libraries.<sup>85</sup> As we gain more experience with this aspect of the support mechanism, we will determine whether an increase in the discount is necessary or advisable. Finally, we disagree with WorldCom that support for Internet access must be based on the difference between urban and rural rates, because section 254(h)(2)(A) of the Act, the statutory provision dealing with information services, makes no reference to an urban-rural comparison, unlike section 254(h)(1)(A).<sup>86</sup> The urban-rural comparison for telecommunications services that Worldcom cites to in section 254(h)(1)(A) does not apply to information services such as Internet access.<sup>87</sup> Provision of Internet access and other information services is governed by section 254(h)(2)(A).<sup>88</sup>

28. Consistent with the Commission's long-standing principles of competitive neutrality, rural health care providers may receive discounts for the most cost-effective form of Internet access, regardless of the platform.<sup>89</sup> Thus, a provider could opt for dial-up Internet access or broadband Internet access over wireline, cable, wireless, or satellite platforms.<sup>90</sup> Health care providers must certify, however, that the particular Internet access service selected is the most cost-effective way of meeting the facility's health care needs.<sup>91</sup> We believe this policy will provide flexibility to rural health care providers to purchase the most appropriate offerings for their health care needs and may also facilitate the deployment of facilities-based broadband

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\$48,000 per provider (\$400 million/8,300). It is unlikely that most entities would receive yearly Internet access discounts anywhere close to this amount. An entity would need to be spending almost \$200,000 per year, or \$16,666 per month, to obtain discounts equivalent to roughly \$48,000, given the twenty-five percent discount we adopt today.

<sup>85</sup> 47 C.F.R. § 54.505(c).

<sup>86</sup> See WorldCom Comments at 5-6 (agreeing that the Commission has the authority to subsidize Internet access but only the difference between rates for urban and rural Internet access); 47 U.S.C. §§ 254(h)(1)(A), 254(h)(2)(A). But see Intelenet Comments at 5; Kingston eHealth Comments at 7-8; Nevada State Office Comments at 6 (agreeing that no urban-rural comparison is necessary).

<sup>87</sup> 47 U.S.C. §§ 254(h)(1)(A), 254(h)(2)(A).

<sup>88</sup> 47 U.S.C. § 254(h)(2)(A).

<sup>89</sup> See 47 U.S.C. § 254(h)(2); 1997 *Universal Service Order*, 12 FCC Rcd at 8801-02, paras. 46-49. We note that health care providers in rural insular areas will be able to receive the twenty-five percent discount off the cost of Internet access even if they are located in the most populous area in the State because no urban-rural comparison is required. See *infra* para. 47.

<sup>90</sup> The comments we received showed that most health care providers prefer broadband technology to dial-up. See Adams Co. Health Dept. Comments at 2; ATA Comments at 11-12; CTL Comments at 11-12; Evangelical Lutheran Comments at 2; GCI Reply Comments at 3-4; Healthcare Anywhere Reply Comments at 4-5.

<sup>91</sup> See *infra* note 184 (defining "cost-effective method").



deployment in rural areas.<sup>92</sup>

29. Moreover, we will continue to provide support for toll charges incurred by health care providers that cannot obtain toll-free access to an ISP, limited to the lesser of \$180.00 or 30 hours of usage per month.<sup>93</sup> The 1997 *Universal Service Order* stated that the proliferation of ISPs and the competitive marketplace “soon should eliminate the need for such support.”<sup>94</sup> However, we are persuaded by commenters’ showings that the need for such support still exists.<sup>95</sup> Providing support for limited toll charges will place those providers who cannot reach an ISP without incurring toll charges on the same footing as other health care providers with respect to Internet access.

## 2. Other Services

30. We decline at this time to provide support for services other than telecommunications services, Internet access, and limited toll charges. In the *NPRM*, the Commission sought comment on whether we should establish new policies to enhance access to advanced telecommunications and information services for health care providers consistent with the scope of our authority under section 254(h)(2)(A).<sup>96</sup> Commenters suggested that telecommunications equipment, surcharges imposed by statewide or regional networks, internal connections, and health care providers’ travel costs should be eligible for universal service support.<sup>97</sup> We find that providing support for telecommunications equipment, surcharges, and travel costs exceeds the scope of our statutory authority under section 254(h), because these items are neither telecommunications nor information services.<sup>98</sup> In addition, we believe there is insufficient information in the record to provide support for internal connections. Moreover, given our experience with the schools and libraries support mechanism, we are concerned that providing support for internal connections may place an undue burden on the rural health care support mechanism.

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<sup>92</sup> Accord Cortland Co. Health Dept. Comments at 2; Evangelical Lutheran Comments at 2; GCI Comments at 7; Intelenet Comments at 6; Lane Co. Health Dept. Comments at 2; NRHA Comments at 2.

<sup>93</sup> 47 C.F.R. §§ 54.601(c)(2), 54.621.

<sup>94</sup> 1997 *Universal Service Order*, 12 FCC Rcd at 9161, para. 748.

<sup>95</sup> See, e.g., Alaska Comments at 3; Arkansas DIS Reply Comments at 1; Florida PSC Comments at 4-6; PA Public Utility Reply Comments at 7. But see Alliance Comments at 1-2; AHA Comments at 4-5; Avera Comments at 1 (advocating elimination of discounts for toll charges).

<sup>96</sup> *NPRM*, 17 FCC Rcd at 7817, para. 26.

<sup>97</sup> See Illinois Center for Rural Health Comments at 3; Washington Rural Comments at 2.

<sup>98</sup> 47 U.S.C. § 254(h). We have previously concluded that the provision of universal service support for telecommunications equipment is outside the scope of our statutory authority. See *Fifteenth Order on Reconsideration*, 14 FCC Rcd at 18780-82, paras. 38-40.

## C. Calculation of Discounted Services

### 1. Interpretation of “Similar Services”

31. *Background.* Section 254(h)(1)(A) of the Act provides that “[a] telecommunications carrier shall, upon receiving a bona fide request, provide telecommunications services which are necessary for the provision of health care services in a State, including instruction relating to such services, to any public or nonprofit health care provider that serves persons who reside in rural areas in that State at rates that are reasonably comparable to rates charged for *similar* services in urban areas in that State.”<sup>99</sup> Our rules do not define “similar” for purposes of comparing urban and rural services.<sup>100</sup> The Commission’s policy has been to calculate discounts for telecommunications services based on the difference between the urban and rural rates for technically similar services.<sup>101</sup>

32. In the *NPRM*, the Commission sought comment on whether the “similarity” of urban and rural services should be determined on the basis of functionality from the perspective of the end user, rather than on the basis of whether urban and rural services are technically similar.<sup>102</sup> The Commission recognized that the current policy may create inequities between urban and rural health care providers.<sup>103</sup> Specifically, the Commission sought comment on whether comparisons should be made between or among different types of high-speed transport offered by telecommunications carriers that may be viewed as functionally equivalent by end users.<sup>104</sup>

33. *Discussion.* We alter our current policy to allow rural health care providers to compare the urban and rural rates for *functionally* similar services as viewed from the perspective of the end user. We agree with commenters that our current policy of comparing technically similar services does not take into account that certain telecommunications services offered in urban areas are not always available in rural areas.<sup>105</sup> In particular, new technologies are often first deployed in urban areas, and such services may be less expensive than services in rural areas based on older technologies. This modification to our rules will better effectuate the mandate of Congress to ensure comparable services for rural areas, as provided in section 254 of the Act, by allowing rural health care providers to benefit from obtaining telecommunications services at rates equivalent to those in urban areas.<sup>106</sup> Eligible health care providers must

<sup>99</sup> 47 U.S.C. § 254(h)(1)(A) (emphasis added).

<sup>100</sup> See 47 C.F.R. §§ 54.605, 54.607, 54.609.

<sup>101</sup> See “Form 466” Instructions, OMB 3060-0804 (April 2001) at 6 (line 30); *NPRM*, 17 FCC Rcd at 7819, para. 34.

<sup>102</sup> *NPRM*, 17 FCC Rcd at 7819, para. 35.

<sup>103</sup> *Id.* at para. 34.

<sup>104</sup> *Id.* at para. 35.

<sup>105</sup> See Illinois Center for Rural Health Comments at 2; Kansas DHE Comments at 2; NM Health Resources Comments at 2; NOSORH Comments at 2; Tri-County Memorial Hosp. Comments at 2; Washington Rural Comments at 3.

<sup>106</sup> 47 U.S.C. § 254.

purchase telecommunications services and compare their service to a functionally equivalent telecommunications service in order to receive this discount.

34. Accordingly, we create “safe harbor” categories of functionally equivalent services based on the advertised speed and nature of the service. For purposes of the rural health care support mechanism only, we establish the following advertised speed categories as functionally equivalent: low – 144-256 kbps; medium – 257-768 kbps; high – 769-1400 kbps (1.4 mbps); T-1 – 1.41-8 mbps;<sup>107</sup> T-3 – 8.1-50 mbps. We will also consider whether a service is symmetrical or asymmetrical when determining functional equivalencies. Telecommunications services will be considered functionally similar when operated at advertised speeds within the same category (low, medium, high, T-1, or T-3) and when the nature of the service is the same (symmetrical or asymmetrical). For example, a symmetrical fractional T-1 service operating at an advertised speed of 144 kbps would be considered functionally similar to a symmetrical DSL transmission service with an advertised speed of 256 kbps.<sup>108</sup> By developing “safe harbor” categories of functionally equivalent speeds, we hope to minimize the disparity in rates of services available in rural and urban areas in an administratively easy fashion. We will update these categories, as needed, to reflect technological developments.

## 2. Urban Area

35. *Background.* Section 254(h)(1)(A) of the Act directs us to provide support for “rates that are reasonably comparable to rates charged for similar services in urban areas in that State.”<sup>109</sup> Thus, under our current rules, for service charges that are not distance-based, qualifying entities receive discounts for the difference, if any, between the urban rate<sup>110</sup> and the rural rate<sup>111</sup> charged for the service.<sup>112</sup> The urban rate is based on the rate for similar services in

<sup>107</sup> For purposes of categorizing functionally similar services, E-1 service is equivalent to US T-1 service.

<sup>108</sup> We specifically refer to rates for a DSL transmission service, and not to rates for a DSL-based Internet access service. The Commission has not determined whether DSL-based Internet access is an information service, or telecommunications service. See generally *Wireline Broadband Internet Access NPRM*. We also decline, at this time, to consider, for purposes of making a comparison of functionally similar services, cable modem services to be a telecommunications service, pending the issuance of a non-appealable final judicial decision concluding that it constitutes a telecommunications service. See generally *Brand X Internet Services v. FCC*, No. 02-70518, FCC No. FCC-Act 2-77, 2003 WL 22283874 (9<sup>th</sup> Cir. 2003) (*Brand X v. FCC*).

<sup>109</sup> 47 U.S.C. § 254(h)(1)(A).

<sup>110</sup> The urban rate is currently defined as a rate no higher than the highest tariffed or publicly-available rate charged to a commercial customer for a similar service provided over the same distance in the nearest city in the state with a population of at least 50,000. 47 C.F.R. § 54.605(a) (2003). However, if a rural health care provider is seeking discounts for services provided over a distance that is greater than the standard urban distance (SUD) (the average of the longest diameters of all cities with a population of 50,000 or more within the state) for that state, the urban rate for purposes of the calculation is the rate charged for a similar service provided over the SUD in the nearest city in the state with a population of at least 50,000. 47 C.F.R. § 54.605(b) (2003).

<sup>111</sup> The current rural rate is the average of the rates actually being charged to commercial customers, other than health care providers, for identical or similar services provided by the telecommunications carrier providing the service in the rural area in which the health care provider is located. 47 C.F.R. § 54.607(a) (2003).

<sup>112</sup> 47 C.F.R. § 54.609(a).

the "nearest large city," defined as "the city located in the eligible health care provider's state, with a population of at least 50,000, that is nearest to the healthcare provider's location, measuring point to point, from the health care provider's location to the point on that city's jurisdictional boundary closest to the health care provider's location."<sup>113</sup>

36. In the *NPRM*, the Commission sought comment on whether to alter our rules to allow comparison of rural rates with rates in any urban area in the state, not only comparison with the rates in the nearest city with a population of over 50,000.<sup>114</sup> The Commission noted that evidence suggests that the largest cities in a state have significantly lower rates and more service options than the nearest city of at least 50,000 to the health care provider.<sup>115</sup> The Commission also sought comment on whether this proposal is the best way to effectuate the statutory mandate.<sup>116</sup> Finally, the Commission also invited comment on the potential effect this change may have on demand for support under the rural health care mechanism.<sup>117</sup>

37. *Discussion.* We now revise section 54.605 of our rules to allow rural health care providers to compare rural rates to urban rates in any city with a population of at least 50,000 in the state, as opposed to the nearest city with a population of 50,000.<sup>118</sup> The Commission originally required comparison to the nearest city with 50,000 people, in part, because they believed health care providers would likely connect to a point in that nearest large city.<sup>119</sup> Based on our experience with the program and information in the record, health care providers may not always find the needed expertise in the nearest large city.<sup>120</sup> Allowing comparison to rates in any city in the state acknowledges that rural health care providers may communicate with experts in other cities in the state. Such action also should allow rural health care providers to benefit from the lowest rates for services in the State, thereby providing additional support to develop better telemedicine links. Verizon asserts that, under this policy, rural health care providers may receive better rates than those available in some urban areas of the state.<sup>121</sup> However, we believe that the public interest in providing more flexibility in utilizing telemedicine services and quality health care facilities outweighs any minimal advantage gained

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<sup>113</sup> 47 C.F.R. § 54.605(c).

<sup>114</sup> *NPRM*, 17 FCC Rcd at 7821, para. 42.

<sup>115</sup> *Id.*

<sup>116</sup> *Id.* at para. 43.

<sup>117</sup> *Id.*

<sup>118</sup> 47 C.F.R. § 54.605 as adopted herein. For example, if a rural health care provider is charged by its telecommunications provider \$250.00 for installation of an ISDN-128 Kbps line, and is charged \$175.00 monthly for the service, but the urban rate in a city in the state is only \$150.00 for installation and \$100.00 per month for service, the telecommunications service provider would give the rural health care provider a one-time installation credit of \$100.00 and give a discount of \$75.00 monthly.

<sup>119</sup> 1997 *Universal Service Order*, 12 FCC Rcd at 9125, para. 670.

<sup>120</sup> See, e.g., CA Primary Care Assoc. Comments at 2; NSRHN Comments at 9.

<sup>121</sup> See Verizon Comments at 14; see also WorldCom Comments at 8.

by rural health care providers over those health care providers located in certain urban areas.<sup>122</sup> Further, we do not believe the urban rates within states differ so significantly that revising this rule will increase demand to the extent that we may risk exceeding the funding cap of \$400 million.

### 3. Maximum Allowable Distance

38. *Background.* Pursuant to our rules, the Administrator determines the “standard urban distance,” (SUD) which is the average of the longest diameters of all cities in the state with a population of at least 50,000.<sup>123</sup> The Administrator also calculates the Maximum Allowable Distance (MAD), which is the distance between the rural health care provider and the farthest point on the jurisdictional boundary of the nearest large city in the state with a population of at least 50,000.<sup>124</sup> Under our rules, for distance-based charges, qualifying entities that connect to locations within or outside of the state receive discounts for services over any distance greater than the SUD but less than the MAD.<sup>125</sup>

39. In the *NPRM*, the Commission sought comment on whether to eliminate or revise the MAD restriction in our rules.<sup>126</sup> The Commission further invited comment on, in lieu of eliminating the restriction, whether it should modify it or adopt another limitation, such as the greatest distance between the location of the rural health care provider and the furthest point on the border of the same state or the distance between the health care provider and the nearest point of tertiary care.<sup>127</sup>

40. *Discussion.* We revise the MAD to equal the distance between the rural health care provider and the farthest point on the jurisdictional boundary of the largest city in that State.<sup>128</sup>

<sup>122</sup> Numerous commenters support modification of this rule to permit rural health care providers to receive support based on a comparison to the lowest rates available in any urban area in the state. See Adams Co. Health Dept. Comments at 3; Alaska Comments at 4; AHA Comments at 7; ASTA Comments at 8-12; ATA Comments at 6; Arkansas DIS Reply Comments at 2; Blue Cross Comments at 6; CA Primary Care Assoc. Comments at 2; CTTC Comments at 6; Illinois Center for Rural Health Comments at 1-2; CTL Comments at 6; Cortland Co. Health Dept. Comments at 2; Healthcare Anywhere, Inc. Comments at 5; Institute of Rural Health Comments at 6; Kansas DHE Comments at 2; Kansas Hosp. Assoc. Comments at 2; Madden Comments at 1; Kingston eHealth Comments at 5; Lane Co. Health Dept. Comments at 2; MGHS Reply Comments at 4-5; Minn. Ambulance Assoc. Comments at 2; MHTA Comments at 3; NACCHO Comments at 2; NRHA Comments at 2; NTCA Comments at 7; Nebraska Office of Rural Health Comments at 1; NM Health Resources Comments at 1; NSRHN Comments at 9; NOSORH Comments at 2; Poudre Valley Health Comments at 1; Tri-County Memorial Hosp. Comments at 1; UVA Comments at 14-15; Washington Rural Comments at 3; WGA Comments at 3.

<sup>123</sup> 47 C.F.R. § 54.605(d).

<sup>124</sup> 47 C.F.R. § 54.613.

<sup>125</sup> 47 C.F.R. § 54.609. For example, if a rural health care provider has a dedicated T-1 line from its site to an urban hospital with a circuit distance of 100 miles, the MAD is 125 miles, the carrier charges \$10 per mile for the line, and the SUD in the state is 10 miles, it would be eligible for \$900 discount per month (the circuit distance of 100 miles less the SUD of 10 miles, multiplied by the rate of \$10 per mile per month).

<sup>126</sup> *NPRM*, 17 FCC Rcd at 7822, para. 45.

<sup>127</sup> *Id.* at 7823, para. 48.

<sup>128</sup> 47 C.F.R. § 54.625(a) as adopted herein.

Accordingly, for distance-based charges actually incurred, we modify our rules to provide support to rural health care providers to any location that exceeds the SUD and is less than this revised MAD.<sup>129</sup> As the Commission indicated in the *NPRM*, our experience to date suggests that limiting rural health care providers to discounts for distance-based charges to the nearest city of 50,000 or more may not be adequate for purposes of creating a comprehensive telehealth and telemedicine network.<sup>130</sup> Further, commenters contend that the current MAD assumes that the rural health care provider will connect with specialists in the nearest urban area, which may not necessarily have the essential complement of specialists to provide telemedicine services.<sup>131</sup> We believe, in most instances, calculating the MAD as described above will provide more support for distance-based charges than our current rules, without creating additional administrative burdens for the Administrator. In addition, this modification should provide rural health care providers access to high levels of care and greater flexibility in developing appropriate telehealth networks.

41. Although commenters generally favor eliminating the MAD,<sup>132</sup> we decline to do so at this time. We are concerned that eliminating the MAD could result in wasteful expenditures for the program, as providers could connect to more distant locations when a closer one would suffice. Expanding the MAD to the largest city in a state should provide support sufficient to enable rural health care providers to connect with health care facilities with a wide range of medical expertise, without introducing the potential for waste associated with eliminating the MAD or making the MAD equal to the furthest point in the state. Moreover, we decline to expand the MAD to equal the distance between the health care provider and the nearest center of tertiary care.<sup>133</sup> Although this proposal may have a more direct relationship to health care services, we agree with commenters that the nearest point of tertiary care may not provide the required specialized expertise.<sup>134</sup> In addition, this proposal would require the identification and continued monitoring of all tertiary care centers throughout the Nation, which would impose significant administrative burdens upon the Administrator of the program.

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<sup>129</sup> 47 C.F.R. § 54.609(a)(1)(ii) as adopted herein.

<sup>130</sup> *NPRM*, 17 FCC Rcd at 7822, para. 45; *see* Adams Co. Health Dept. Comments at 2; AFHCAN Comments at 7; AHA Comments at 7; CA Primary Care Assoc. Comments at 2; Cortland Co. Health Dept. Comments at 3; Institute of Rural Health Comments at 7; NACCHO Comments at 2; NRHA at 2.

<sup>131</sup> *See, e.g.*, CA Primary Care Assoc. Comments at 2; NSRHN Comments at 9.

<sup>132</sup> *See, e.g.*, Adams Co. Health Dept. Comments at 2; AFHCAN Comments at 7; Alaska Comments at 5; Alaska Telehealth Comments at 3; ASTA Comments at 8; Arkansas DIS Reply Comments at 2; Blue Cross Comments at 7; CA Primary Care Assoc. Comments at 2; Tri-County Memorial Hosp. Comments at 1; Washington Rural Comments at 2; WGA Comments at 3.

<sup>133</sup> The Commission sought comment on this option in the *NPRM*. *NPRM*, 17 FCC Rcd at 7823, para. 48. Noting that it was unable to identify the criteria for determining the nearest point of tertiary care, the Commission also sought comment on how to define the point of tertiary care. No commenter submitted information on the definition of a point of tertiary care.

<sup>134</sup> *See* NSRHN Comments at 10 (opposing limiting MAD to nearest point of tertiary care in part because not all tertiary care services are offered in all urban communities); *see also* Kingston eHealth Comments at 5-6 (noting that the Pacific jurisdictions lack tertiary hospitals with specialty care).

#### 4. Satellite Services

42. *Background.* Under the Commission's policies, as indicated above, the cost of rural satellite service is compared to the cost of urban satellite service.<sup>135</sup> Because the price of satellite service typically does not vary by location, rural health care providers using satellite services generally do not receive discounts under the rural health care program.<sup>136</sup> However, there is an exception that allows for some support for satellite service. Rural health care providers that are located in areas with no terrestrial-based alternative may compare rural satellite rates to urban wireline rates, which results in support for such providers.<sup>137</sup>

43. In the *NPRM*, the Commission sought comment on whether to modify our rules governing discounts for satellite services.<sup>138</sup> Specifically, the Commission sought comment on how a modification to our current policy to base discounts on the difference in urban and rural rates between functionally similar services would affect health care providers seeking discounts for satellite services.<sup>139</sup> The Commission recognized that rural health care providers using satellite services, particularly in remote and insular areas, have been disadvantaged under our current policy because, in many instances, satellite systems provide the only viable means for providers to receive telecommunications services.<sup>140</sup>

44. *Discussion.* We revise our policy to allow rural health care providers to receive discounts for satellite services even where alternative terrestrial-based services may be available. As suggested by commenters, however, these discounts will be capped at the amount providers would have received if they purchased functionally similar terrestrial-based alternatives.<sup>141</sup> Providers seeking discounts for satellite services will be required to provide to the Administrator documentation of the urban and rural rates for the terrestrial-based alternative services. We believe imposing a cap on support for satellite service is necessary because satellite services are often significantly more expensive than terrestrial-based services. Thus, pursuant to these changes, where rural health care providers opt for more expensive satellite-based services when a cheaper terrestrial-based alternative is available, the provider, and not the support mechanism, will be responsible for the additional cost. For example, if a health care provider pays \$100 per month for satellite service, the rural rate for a comparable wireline service plan is \$60 per month, and the urban rate is \$40 per month, the health care provider would receive \$20 per month towards the satellite service. We conclude this approach furthers

<sup>135</sup> See *supra* para. 35; 47 C.F.R. §§ 54.605, 54.607, 54.609.

<sup>136</sup> *NPRM*, 17 FCC Rcd at 7820, para. 38.

<sup>137</sup> Currently, only rural health care providers in Alaska have received support for satellite services pursuant to this policy.

<sup>138</sup> *NPRM*, 17 FCC Rcd at 7820, para. 38.

<sup>139</sup> *Id.*

<sup>140</sup> *Id.*

<sup>141</sup> See Kansas DHE Comments at 2; Kansas Hosp. Assoc. Comments at 3; UVA Comments at 14; MSV Reply Comments at 6 (suggesting the Commission compare the rural terrestrial cost of mobile services to the urban terrestrial cost and apply that same discount to satellite).

the principle of competitive neutrality and recognizes the role that satellite services may play in rural areas without unduly increasing the size of the fund. We also seek further comment in the accompanying *Further Notice* on whether additional rule changes should be adopted to facilitate support for mobile rural health care providers.<sup>142</sup>

## 5. Insular Areas

45. *Background.* Section 254(h)(1)(A) provides that telecommunications carriers must offer telecommunications services to rural health care providers “at rates that are reasonably comparable to rates charged for similar services in urban areas *in that State*.”<sup>143</sup> Consistent with this statutory language, for purposes of calculating the “urban rate” to determine the amount of universal service support received by rural health providers in insular areas,<sup>144</sup> the Commission looks at the rates charged customers for a similar service in the largest population center in the State.<sup>145</sup> The Commission, however, has recognized that use of this calculation may be ill-suited for insular areas because many rural health care providers are located in the largest population center in the territory, which results in no recognizable urban/rural rate comparison.<sup>146</sup> Accordingly, in the *NPRM*, the Commission sought comment on whether section 254(h)(2)(A) gives us the authority to allow rural health care providers to receive discounts by comparing the rural rate to the nearest large city outside of their “State.”<sup>147</sup> The Commission also sought comment on alternative means for addressing the problems of insular areas, consistent with section 254.<sup>148</sup>

46. *Discussion.* Although we continue to recognize that using urban rates within a State as the benchmark for reasonable rates may be ill-suited to certain insular areas, we believe that the proposal of some commenters<sup>149</sup> to permit the comparison of insular rural rates to the

<sup>142</sup> See *infra* paras. 64-67.

<sup>143</sup> 47 U.S.C. § 254(h)(1)(A) (emphasis added). The Commission determined that the provisions of section 254(h)(1)(A) apply to insular areas because the Act defines “State” to include all “territories and possessions” of the United States. 47 U.S.C. §153(40); see *1997 Universal Service Order*, 12 FCC Rcd at 9135, para. 692.

<sup>144</sup> The term “insular area,” includes but is not limited to, American Samoa, the U.S. Virgin Islands, Commonwealth of the Northern Mariana Islands, Guam and Puerto Rico. *1997 Universal Service Order*, 12 FCC Rcd at 9136, para. 695 n.1820.

<sup>145</sup> 47 C.F.R. §§ 54.605-609 (2003). The Commission designated the largest population center as the urban area for insular areas since many insular areas do not have cities with populations as large as 50,000. *1997 Universal Service Order*, 12 FCC Rcd at 9136-38, paras. 693-69.

<sup>146</sup> *NPRM*, 17 FCC Rcd at 7823-24, para. 49.

<sup>147</sup> *Id.* at 7824, para. 50. The Commission also sought comment in the *Unserved and Underserved Areas Further Notice* on this specific issue. *Federal-State Joint Board on Universal Service; Promoting Deployment and Subscribership in Unserved and Underserved Areas, Including Tribal and Insular Areas*, CC Docket No. 96-45, *Further Notice of Proposed Rulemaking*, 14 FCC Rcd 21177, 21235-36, para. 143 (1999) (*Unserved and Underserved Area Further Notice*).

<sup>148</sup> *NPRM*, 17 FCC Rcd at 7824, para. 50.

<sup>149</sup> See, e.g., Alaska Comments at 5; American Samoa Medical Center Comments at 2; ASTA Comments at 3-6; ATA Comments at 13; CTL Comments at 13; Guam Dept. of PHSS Comments at 1. Specifically, they suggest (continued....)



nearest urban area outside the State is inconsistent with the statutory language set forth in section 254(h)(1)(A).<sup>150</sup> As the Commission indicated in the *Fifteenth Order on Reconsideration*, Congress could have provided discounts for telecommunications services that connect rural health care providers to the nearest major hospital within or outside the State.<sup>151</sup> Congress, however, explicitly provided that rates should be compared to the urban rate in that State.<sup>152</sup> We continue to believe section 254(h)(1)(A) precludes us from designating an urban area outside of the State as the benchmark for comparison for remote, insular areas.<sup>153</sup>

47. We also disagree with American Samoa Telecommunications Authority that section 254(h)(2)(A) authorizes the Commission to provide support for telecommunication links between American Samoa to an urban center outside the territory, such as Honolulu, Hawaii, without regard to the urban-rural rate difference.<sup>154</sup> Section 254(h)(2)(A) authorizes the Commission to take action to increase access to advanced telecommunications and information services.<sup>155</sup> Support for telecommunications services, however, is provided subject to section 254(h)(1)(A) and as discussed herein, requires an urban to rural comparison within the State. Although we do not believe we can grant the request of providers in insular areas, we do provide support for Internet access for all eligible rural health care providers, including those in insular areas, which we believe will functionally provide significant support to health care providers in insular areas.<sup>156</sup>

#### **D. Other Changes to the Rural Health Care Support Mechanism**

##### **1. Allocation Guidelines and Record-Keeping Requirements**

48. *Background.* Under the Commission's rules, rural health care providers that receive support under the rural health care universal service support mechanism are subject to record-keeping and record production requirements, and random audits to ensure compliance.<sup>157</sup> In the *NPRM*, we sought comment on the effectiveness of our current rules regarding audits, and other

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designating Honolulu, Hawaii, as the urban center for comparison for insular areas. *See, e.g.,* American Samoa Medical Center Comments at 2; FRC Reply Comments at 4; Guam Dept. of PHSS Comments at 1; Guam Memorial Hosp. Comments at 2; HTC Reply Comments at 2; IT & E Comments at 1-2.

<sup>150</sup> 47 U.S.C. § 254(h)(1)(A).

<sup>151</sup> *Fifteenth Order on Reconsideration*, 14 FCC Rcd at 18784, para. 44.

<sup>152</sup> 47 U.S.C. § 254(h)(1)(A).

<sup>153</sup> *Id.*

<sup>154</sup> ASTA Comments at 11.

<sup>155</sup> 47 U.S.C. § 254(h)(2)(A).

<sup>156</sup> For example, if an eligible rural health care provider in American Samoa purchased Internet access via satellite, it would receive a twenty-five percent discount on the price for that service. *See supra* paras. 27-28.

<sup>157</sup> *See generally* 47 C.F.R. § 54.619.

procedures to ensure the appropriate use of funds available under this support mechanism.<sup>158</sup>

49. *Discussion.* Because entities that engage in both eligible and ineligible activities or that collocate with an entity that provides ineligible services will now be eligible for prorated support, we adopt rules requiring such providers to allocate their discounts to prevent discounts from flowing to ineligible activities or providers of services.<sup>159</sup> Prorated discounts will be provided commensurate only with entities' eligible activities. The method of cost allocation chosen by an applicant should be based on objective criteria, and reasonably reflect the eligible usage of the facilities.<sup>160</sup> Thus, if telecommunications facilities are used jointly for eligible and ineligible purposes, the allocation should be based on the percentage of time the facility is used for eligible purposes or some other method that reasonably reflects eligible usage. Health care providers must keep documentation explaining their allocation methods for five years and present that information to USAC upon request.<sup>161</sup> We also direct USAC to evaluate the allocation methods selected by program participants in the course of its audit activities to ensure program integrity. Additionally, we codify the requirement that health care providers must maintain records for their purchases of supported services for at least five years sufficient to document their compliance with all Commission requirements.<sup>162</sup>

50. To illustrate the general principle of discount allocation, we provide several "safe harbor" examples of allocation methods. First, if a dedicated emergency department in a for-profit rural hospital shares access to a T-3 with the rest of the hospital, and the T-3 is used seventy-five hours per week related to EMTALA-emergency care and the education of health care professionals who work in the dedicated emergency department and fifty hours per week related to other hospital use, the T-3 would be used for eligible purposes sixty percent of the time (seventy-five hours of use by emergency department divided by 125 total hours of use by the entire hospital). Therefore, the eligible dedicated emergency department would receive sixty percent of the difference between the urban and rural rate for the T-3. Second, another dedicated emergency department in a for-profit rural hospital that shares access to a T-3 with the rest of the hospital, might choose to allocate discounts based on employee hours. For example, if the emergency department staff, including on-call physicians, is staffed at 3,360 hours per week (twenty employees covering 168 hours per week), and the rest of the hospital is staffed at 4,000 hours per week (100 employees covering 40 hours per week), the emergency department would receive forty-six percent of the difference between the urban and rural T-3 rate (3,360 emergency staff hours divided by 7,360 total staff hours). Third, if a non-profit rural

<sup>158</sup> *NPRM*, 17 FCC Rcd at 7827, para. 61.

<sup>159</sup> 47 C.F.R. § 54.601(d) as adopted herein; *Accord* Intelenet Comments at 2 (encouraging the Commission to modify its rules so that an otherwise eligible health care provider that is collocated with an ineligible entity may be considered for partial universal service support).

<sup>160</sup> 47 C.F.R. § 54.601(d) as adopted herein.

<sup>161</sup> See 47 C.F.R. § 54.619(a)(1) as adopted herein. Participants in the schools and libraries program are also required under USAC procedures to retain documentation for five years. See Universal Service Administrative Company: Records Retention, available at <http://www.sl.universalservice.org/applicants/records.asp> (retrieved November 13, 2003).

<sup>162</sup> 47 C.F.R. § 54.619(a)(1) as adopted herein. See also FCC Form 466 Instructions.

health clinic operates in a local community center for five hours one evening per week and uses the community center's T-1 line, and the community center's normal operating hours are 10 AM – 10 PM, Monday thru Saturday, the T-1 would be used for eligible purposes seven percent of the time (five hours divided by eighty-four open hours in a week). Therefore, the eligible non-profit rural health clinic would receive seven percent of the difference between the urban and rural rate for the T-1. Fourth, if a dedicated emergency department in a for-profit rural hospital shares access to a T-1 with the rest of the hospital, and the dedicated emergency department occupies 250 square feet and the hospital occupies 2,500 square feet, the T-1 would be used for eligible purposes ten percent of the time (250 square feet divided by 2,500 square feet). Therefore, the eligible dedicated emergency department would receive ten percent of the difference between the urban and rural rate for the T-1. If a rural health care provider can document that it adopted an allocation method consistent with one of these four examples, we will consider the method compliant with our requirements. Rural health care providers may choose a different allocation method, but will bear the burden of demonstrating, in the event of an audit or otherwise, that the chosen method was based on objective criteria and reasonably reflects the eligible usage of the facilities.

51. Conversely, when services are used solely by an eligible entity for eligible purposes, no allocation would be necessary. For example, if a T-1 is located solely in the dedicated emergency room and is used only for medical or educational purposes, the dedicated emergency room would be able to receive the full discount based on the difference between the urban and rural rate. Similarly, if there is a phone line in a private room at the community center that is dedicated exclusively to a rural health care clinic, no allocation would be necessary because the personnel staffing the part-time rural health care clinic would be the only ones to use the phone.

## 2. Streamlining the Application Process

52. *Background.* In the *NPRM*, we sought comment on ways to streamline the application process to make it more accessible and reduce overall administrative costs to rural health care providers.<sup>163</sup> Commenters suggested USAC streamline the application process by pre-filling forms for repeat applicants,<sup>164</sup> combining or eliminating forms,<sup>165</sup> implementing on-line filing<sup>166</sup> and e-certification capability,<sup>167</sup> simplifying the process for identifying urban

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<sup>163</sup> *NPRM*, 17 FCC Rcd at 7825, para. 51.

<sup>164</sup> See ATA Comments at 7-9; CTL Comments 7-9; Institute of Rural Health Comments at 7; Madden Comments at 1; MGHS Reply Comments at 3; MHTA Comments at 2; NM Health Resources Comments at 2; NSRHN Comments at 10-11; Northwest TeleHealth Comments at 2; NOSORH Comments at 2; Tri-County Memorial Hosp. Comments at 2; Univ. of Arizona Health Sciences Comments at 2; Washington Rural Comments at 3; UVA Comments at 18-19.

<sup>165</sup> See AFHCAN Comments at 7; Alaska Telehealth Comments at 3; Blue Cross Comments at 4; GCI Comments at 9; GCI Reply Comments at 6; Nebraska Office of Rural Health Comments at 1-2; Kansas DHE Comments at 2; Kansas Hosp. Assoc. Comments at 2.

<sup>166</sup> See AHA Comments at 8; Avera Comments at 4.

<sup>167</sup> See Blue Cross Comments at 5; NSRHN Comments at 10-11.

rates,<sup>168</sup> and conducting more outreach efforts.<sup>169</sup> Moreover, some commenters suggested that discount payments should be provided directly to health care providers. They argue the current system, which provides discounts directly to service providers after the required paperwork is processed, who in turn provide discounted services to health care providers, results in health care providers having to “front load” the costs of the discount while USAC develops the payment schedule with the service provider.<sup>170</sup>

53. *Discussion.* Since the *NPRM* was released, USAC has streamlined the application process significantly in response to the numerous comments submitted in this proceeding on this issue.<sup>171</sup> For example, USAC has implemented electronic filing and e-certification for all forms<sup>172</sup> and has arranged for electronic forms to be filled automatically with the previous year's information for repeat on-line filers.<sup>173</sup> USAC has also created a database of urban rates on its website.<sup>174</sup> As a result, a health care provider can now bypass the arduous step of having to retrieve this information from its carrier. In addition, USAC has significantly expanded its outreach efforts, such as by sending mailings to carriers and health care providers to alert them

<sup>168</sup> See ATA Comments at 7-9; CTL Comments at 7-9; NTCA Comments at 5; Poudre Valley Health Comments at 1; WorldCom Comments at 9-10.

<sup>169</sup> See generally Alaska Comments at 5, 8; Alliance Comments at 5-6; AHA Comments at 8; Arizona Telemedicine Comments at 2; Arkansas DIS Reply Comments at 1; Illinois Center for Rural Health Comments at 2; Florida PSC Comments at 7-8; Kansas DHE comments at 3; Kansas Hosp. Assoc. Comments at 3; Madden Comments at 1; MGHS Reply Comments at 3; Mayo Comments at 1; Nevada State Office Comments at 9; NM Health Resources Comments at 2; NOSORH Comments at 2; Univ. of Arizona Health Sciences Comments at 2; Washington Rural Comments at 3; Tri-County Memorial Hosp. Comments at 2; WorldCom Comments at 9-10.

<sup>170</sup> See ATA Comments at 7-9; Blue Cross Comments at 5-6; CTTC Comments at 7; CTL at 7-9; Grogg Comments at 2; Institute of Rural Health Comments at 4; MGHS Reply Comments at 3; MHTA Comments at 2; NSRHN Comments at 10-11; Northwest TeleHealth Comments at 4; Univ. of Tennessee Health Science Comments at 2-3.

<sup>171</sup> See generally AFHCAN Comments at 6-7; Alaska Comments at 5; Alaska Telehealth Comments at 3; Alliance Comments at 3-4; AHA Comments at 8-9; ATA Comments at 7-9; Arizona Telemedicine Comments at 2; Arkansas DIS Reply Comments at 1; Avera Comments at 4; Blue Cross Comments at 4-5; Illinois Center for Rural Health Comments at 2; CTL Comments 7-9; Clifford Comments at 1; GCI Comments at 9; GCI Reply Comments at 6; Institute of Rural Health Comments at 7; Kansas DHE Comments at 2; Madden Comments at 1; MGHS Reply Comments at 3; Minn. Ambulance Assoc. Comments at 2; Nebraska Office of Rural Health Comments at 1-2; Nevada State Office Comments at 9; NM Health Resources Comments at 2; NSRHN Comments at 10-11; Northwest TeleHealth Comments at 2; NOSORH Comments at 2-3; SBC/BellSouth Joint Reply Comments at 4; Tri-County Memorial Hosp. Comments at 1-2; Univ. of Arizona Health Sciences Comments at 2; Washington Rural Comments at 3, 5; WorldCom Comments at 9-10; UVA Comments at 18-19. See also Universal Service Administrative Company: Funding Year 2003 Process Overview, available at [http://www.rhc.universalservice.org/overview/processoverview\\_2003.asp](http://www.rhc.universalservice.org/overview/processoverview_2003.asp) (retrieved November 13, 2003).

<sup>172</sup> USAC launched e-certification for FCC Form 465 on January 28, 2002. New applicants or applicants that have not enabled e-certification must print, sign, and mail a paper FCC Form 465 to USAC. USAC launched e-certification for FCC Form 466 on June 19, 2003 and for FCC Form 467 on April 29, 2002.

<sup>173</sup> USAC launched pre-filled FCC Form 465 on January 1, 2002, pre-filled FCC Form 466 on June 19, 2003, and pre-filled FCC Form 467 on April 29, 2002.

<sup>174</sup> See Universal Service Administrative Company: Urban Rates, available at <http://www.universalservice.org/rhcd/urbanrates/search.asp> (retrieved November 13, 2003).

to changes in the program, holding monthly conference calls for carriers and health care providers to ask questions and raise concerns, and setting up a toll-free access number where carriers and health care providers can call at their convenience.<sup>175</sup> Finally, USAC has eliminated the form submitted by service providers, FCC Form 468, by combining the relevant information into FCC Form 466, which is submitted by applicants.<sup>176</sup> This modification to the reimbursement process has reduced to a great extent the interval between receipt of service and payments to service providers, thereby mitigating commenters' concerns.

54. We believe USAC's efforts to ease the burdens of applying to the program have been exemplary, as further evidenced by the number of completed applications received by USAC in Funding Year 2003 compared to Funding Year 2002. Nevertheless, in the *Further Notice of Proposed Rulemaking*, we seek comment on ways in which USAC could further streamline the application process and expand outreach efforts. In addition, we note that the Commission, through the Consumer & Governmental Affairs Bureau, will endeavor through its educational and outreach efforts, to ensure that those most likely affected are informed about the actions taken in this Order. In addition to making fact sheets and other informational materials available for dissemination through the Commission's website, the Commission will include the dissemination of such information as part of its on-going, grassroots outreach efforts directed at rural America and undertaken in coordination with other federal and state agencies.

### 3. Pro-Rata Reductions If Annual Cap Exceeded

55. *Background.* The annual cap on universal service support for health care providers is currently \$400 million per funding year.<sup>177</sup> Generally, funds are available to applicants filing requests on a first-come-first-served basis.<sup>178</sup> If the total demand for support in a year exceeds the cap, however, the Administrator shall divide the total annual support available by the total amount requested in that year, and multiply that result, which is the pro-rata factor, by the amount requested by each applicant, in order to determine the amount each applicant shall receive.<sup>179</sup> Only applicants that file within the filing window will receive pro-rata support under these circumstances. The filing window date for each Funding Year is posted on USAC's homepage.<sup>180</sup> To date, discount amounts requested under the rural health care universal service support mechanism have never exceeded the annual cap. In light of potential changes to the

<sup>175</sup> See generally USAC's website found at <http://www.rhc.universalservice.org>.

<sup>176</sup> On June 19, 2003, USAC eliminated Form 468 from Funding Year 2003 onward. See Universal Service Administrative Company: FCC Form 468 Eliminated for Funding Year 2003, available at <http://www.rhc.universalservice.org/whatsnew/062003.asp#2> (retrieved November 13, 2002). See also Kansas DHE Comments at 2 and KHA Comments at 2 (suggesting that Form 468 be eliminated to streamline application process because telecommunication carriers struggle to complete the form in a timely manner).

<sup>177</sup> 47 C.F.R. § 54.623(a).

<sup>178</sup> 47 C.F.R. § 54.623(c)(1).

<sup>179</sup> 47 C.F.R. § 54.623(f).

<sup>180</sup> See USAC's homepage available at <http://www.rhc.universalservice.org/homepage.asp> (retrieved November 13, 2003). For example, the filing window for Funding Year 2003 runs from March 26-June 2, 2003. See also 47 C.F.R. § 54.623(c).

program, we sought comment in the *NPRM* on whether to modify our current rules governing the allocation of funds under the rural health care universal service support mechanism if demand should exceed the annual cap.<sup>181</sup>

56. *Discussion.* Based on our estimates and the comments we have received, we continue to believe that our current rules requiring pro-rata distribution of funds if requests exceed the cap, are the most effective and equitable means of distributing limited funds in accordance with the goals and purposes of the statute. Therefore, we agree with the majority of commenters that the current rules should be maintained.<sup>182</sup> We note that the rules adopted in this Order could increase the level of discounts requested in a year, so applicants are encouraged to submit applications during the filing window to secure their universal service funding. We disagree with the commenter that suggested we prioritize universal service support for telecommunication services over information services.<sup>183</sup> We do not think such a measure is necessary at this time because program demand has never approached the cap. Moreover, prioritization would add another level of unnecessary administrative complexity to the support mechanism.

#### 4. Ensuring the Selection of Cost-Effective Services

57. *Background.* Current rules require rural health care applicants to consider all bids received in response to the posting on USAC's webpage of their Description of Services Requested Form (FCC Form 465) and certify that they have selected the most cost-effective method of providing the requested services to meet its' health care telecommunications needs.<sup>184</sup> There are no restrictions, however, on the type of service offerings a rural health care provider may select. In the *NPRM*, we sought comment on whether there currently are adequate measures to ensure that rural health care providers purchase the most cost-effective services.<sup>185</sup> We also sought comment on whether we should implement changes to encourage applicants to use the lowest-cost technology available.<sup>186</sup>

58. *Discussion.* We agree with commenters that the current rules are adequate to ensure that health care providers select the most cost-effective services.<sup>187</sup> Our certification requirements, combined with the requirement that health care providers remain responsible for a significant portion of service costs (*i.e.*, the urban rate of telecommunications services and 75%

<sup>181</sup> *NPRM*, 17 FCC Rcd at 7825, para. 54.

<sup>182</sup> Alliance Comments at 4; Avera Comments at 4; Intelenet Comments at 7; Kansas DHE Comments at 3; Kansas Hosp. Assoc. Comments at 3; PA Public Utility Reply Comments at 8.

<sup>183</sup> See GCI Comments at 9; GCI Reply Comments at 6.

<sup>184</sup> The most cost-effective method is defined as "the method that costs the least after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems relevant . . ." 47 C.F.R. § 54.615(c)(7). See also *supra* para. 28.

<sup>185</sup> *NPRM*, 17 FCC Rcd at 7827, para. 59.

<sup>186</sup> *Id.*

<sup>187</sup> Alliance Comments at 5; MSV Comments at 7.

of Internet access) will ensure that rural health care providers make prudent economic decisions.<sup>188</sup> We also agree with commenters that applicants should not be required to use the lowest-cost technology because factors other than cost, such as reliability and quality, may be relevant to fulfill their telemedical needs.<sup>189</sup>

## 5. Other Non-Substantive Rule Changes

59. In the *NECA Order*, the Commission directed the National Exchange Carrier Association (NECA) to establish the Rural Health Care Corporation to administer the rural health care support mechanism.<sup>190</sup> Subsequently, the Commission directed the Rural Health Care Corporation to be merged into a division of USAC.<sup>191</sup> In light of the Commission's prior actions, we hereby amend our rules to replace all references to the "Rural Health Care Corporation" with the "Rural Health Care Division."<sup>192</sup> We also revise section 54.609(a)(1)(i) to conform to the *Fifteenth Order on Reconsideration*.<sup>193</sup> We also adopt several other non-substantive rule changes to improve the clarity of the rules.<sup>194</sup>

## 6. Implementation

60. Funding Year 2003 for the rural health care program ends June 30, 2003, and Funding Year 2004 begins July 1, 2004. Because we do not wish to introduce changes to the program in the middle of a funding year, the modifications to the program adopted in this Order will be implemented beginning with Funding Year 2004. We direct USAC to take the necessary operational steps to implement the improvements to the program adopted herein for Funding Year 2004.

# IV. ORDER ON RECONSIDERATION

61. *Background.* In the *1997 Universal Service Order*, the Commission concluded that

<sup>188</sup> Certification that a rural health care provider selects the most cost-effective method, pursuant to § 54.615(c)(7) of our rules, will be extended to include the provision of support for Internet access. 47 C.F.R. § 54.621(a) as adopted herein. See also *supra* note 184 (defining "cost-effective method").

<sup>189</sup> Accord Intelenet Comments at 8 (Intelenet posits that rules requiring applicants to use lowest cost technology available could result in providers being relegated to using obsolete or soon-to-be-retired technology. Sometimes initially higher cost options may prove to be lower in the long-run, by providing useful benefits to telemedicine in terms of scalability, maintenance, and future developments).

<sup>190</sup> *Changes to the Board of Directors of the National Exchange Carrier Association, Federal-State Joint Board on Universal Service*, Report and Order and Second Order on Reconsideration, CC Docket Nos. 97-21, 96-45, 12 FCC Rcd 18400 (1997) (*NECA Order*).

<sup>191</sup> *Changes to the Board of Directors of the National Exchange Carrier Association, Inc., Federal-State Joint Board on Universal Service*, Third Report and Order, Fourth Order on Reconsideration, Eighth Order on Reconsideration, CC Docket Nos. 97-21, 96-45, 13 FCC Rcd 25058 (1998).

<sup>192</sup> 47 C.F.R. § 54.603 as amended herein.

<sup>193</sup> *Fifteenth Order on Reconsideration*, 14 FCC Rcd at 18779 n.122.

<sup>194</sup> See 47 C.F.R. § 54.601 as adopted herein.

telecommunications carriers must charge eligible rural health care providers a rate for each supported service that is no higher than the highest tariffed or publicly available commercial rate for a similar service in the closest city in the state with a population of 50,000 or more.<sup>195</sup> Subsequently, the predecessor to Mobile Satellite Ventures Subsidiary (MSV), filed a Petition for Clarification or Reconsideration of this decision requesting the Commission to establish “that the urban services that are ‘similar’ to [MSV]’s rural [services] are the terrestrial mobile communications services typically used by ambulances and other emergency medical vehicles in a state’s urban areas . . . [and that] support for rural health care providers that use [MSV]’s services should be calculated on the basis of actual airtime usage rates that [MSV] charges for calls outside a customer’s predefined talk-group.”<sup>196</sup> MSV noted that under this approach, market forces and the relative cost-effectiveness of these competing technologies can determine which mobile technology is the most successful in rural and remote areas.<sup>197</sup> In the *NPRM*, the Commission sought comment on MSV’s proposal.<sup>198</sup>

62. *Discussion.* Consistent with the policy objectives underlying our decision as indicated above,<sup>199</sup> we deny, to the extent indicated herein, MSV’s petition for reconsideration of the 1997 *Universal Service Order*.<sup>200</sup> We decline to revise our policy, as MSV suggests, to subsidize satellite service at the same price as terrestrial mobile service.<sup>201</sup> We agree with Verizon that equalizing these rates could undercut competition and competitive neutrality.<sup>202</sup> Although we agree that MSV and similar carriers provide valuable services to rural areas, particularly insular areas unserved by wireline carriers, we are concerned that equalizing the rates for satellite and terrestrial mobile service could significantly increase program demand and disadvantage those carriers already providing functionally similar services at more competitive prices. Accordingly, we deny MSV’s petition for reconsideration to the extent indicated herein.<sup>203</sup>

<sup>195</sup> 1997 *Universal Service Order*, 12 FCC Rcd at 9124-25, paras. 669-70.

<sup>196</sup> AMSC Subsidiary Corporation (AMSC) Petition for Clarification or Reconsideration, filed July 17, 1997, at 8-9 (MSV Petition for Reconsideration). AMSC subsequently changed its name to Mobile Satellite Ventures Subsidiary (MSV); MSV Comments, filed Dec. 20, 2001 (updating its petition for reconsideration).

<sup>197</sup> MSV Petition for Reconsideration at 9.

<sup>198</sup> *NPRM*, 17 FCC Rcd at 7820-21, para. 39.

<sup>199</sup> See *supra* para. 44.

<sup>200</sup> MSV Petition for Reconsideration; see also MSV Comments, filed July 1, 2002. We will address the additional issues raised by MSV in its petition for reconsideration related to the Commission’s high-cost-area support rules in a subsequent order. See MSV Petition for Reconsideration at 5-8.

<sup>201</sup> MSV Petition for Reconsideration at 9.

<sup>202</sup> Verizon Comments at 10.

<sup>203</sup> As discussed above, rural health care providers will be able to apply capped discounts towards satellite service. See *supra* para. 44. In addition, if there is no terrestrial alternative, health care providers may compare the cost of rural satellite service to urban wireline rates. See *supra* para. 42.



## V. FURTHER NOTICE OF PROPOSED RULEMAKING

### A. Definition of "Rural Area"

63. We seek comment on modifications to the definition of "rural area" for the rural health care universal service support mechanism. Currently, an area qualifies as rural if it is located in a non-metropolitan county as defined by the Office of Management and Budget or is specifically identified in the Goldsmith Modification to 1990 Census data published by the Office of Rural Health Care Policy (ORHP).<sup>204</sup> In response to the *NPRM*, several commenters state that ORHP no longer utilizes the definition adopted by the Commission in 1997 and that there will be no Goldsmith Modification to the most recent 2000 Census data.<sup>205</sup> Several commenters suggest that the Commission adopt the rural designation system currently utilized by ORHP, the Rural Urban Commuting Area (RUCA) system.<sup>206</sup> Others propose to define rural as non-urbanized areas, as specified by the Census Bureau.<sup>207</sup> Finally, some commenters assert that if the Commission adopts a new definition of rural, it should grandfather existing areas that currently qualify as rural, if they would no longer qualify under the new definition.<sup>208</sup>

64. We seek comment on whether we should adopt a new definition of rural area for the rural health care program, and, if so, what that new definition should be. We seek comment on whether there are any definitions for rural areas used by other government agencies or medical organizations that would be appropriate for the rural health care program. In addition to describing any proposed new definitions, we ask commenters to address the specific proposals that have already been raised in the record. Commenters are encouraged to describe the effects of any new definition to the program, *e.g.* how many existing rural areas would become non-rural and vice versa. We also seek comment on whether there are reasons we should or should not use the same definition of "rural" for both the rural health care and schools and libraries support mechanisms.<sup>209</sup>

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<sup>204</sup> See 47 C.F.R. § 54.5.

<sup>205</sup> See Kansas DHE Comments at 3.

<sup>206</sup> See, *e.g.*, Illinois Center for Rural Health Comments at 3; NM Health Resources Comments at 3.

<sup>207</sup> See, *e.g.*, ATA Comments at 5; Blue Cross Comments at 4; NSRHN Comments at 7-8. For the 2000 Census, urban territories include urbanized areas (UA) and urban clusters (UC), which consist of core census block groups or blocks that have a population density of at least 1,000 people per square mile and surrounding census blocks that have an overall density of at least 500 people per square mile. Rural territories include areas located outside of UAs and UCs. See *The United States 2000 Census: Census 2000 Urban and Rural Classification*, available at [http://census.gov/geo/www/ua/ua\\_2k.html](http://census.gov/geo/www/ua/ua_2k.html) (retrieved September 11, 2003).

<sup>208</sup> See Midwest Networks Comments at 4.

<sup>209</sup> We note that the schools and libraries support mechanism currently uses the same definition of rural area as the rural health care support mechanism. We will seek comment on possible changes to the rural area definition in the context of the schools and libraries program in a separate notice of proposed rulemaking. We further note that we have sought comment on the appropriate definition of a "rural area" in the context of promoting the rapid and efficient deployment of spectrum-based services in rural areas. We specifically sought comment on the following definitions: (1) counties with a population density of 100 persons or fewer per square mile; (2) RSAs; (3) non-nodal counties within an EA; (4) the definition for "rural" used by the RUS for its broadband program; (5) the definition for "rural area" used by the Commission in connection with universal service support for schools, libraries, and rural (continued....)

## B. Support for Satellite Services for Mobile Rural Health Clinics

65. We also seek comment on whether additional modifications to our rules are appropriate to facilitate the provision of support to mobile rural health clinics for satellite services. Satellite services may be used by mobile rural health clinics that operate in vans or boats to deliver telemedical services via satellite to residents in rural areas. For example, one non-profit entity is launching the first mobile telemammography van to diagnose breast cancer in women in four rural tribal lands in North and South Dakota early next year.<sup>210</sup> This van will conduct mammograms and deliver results to rural American Indian women while they wait.<sup>211</sup> The van's clinician will send the mammogram via satellite, which is contained in sixty-four megabytes of data, to doctors at the University of Colorado, who will diagnose any abnormalities and email the van with the patient's results.<sup>212</sup> The van will serve approximately 12,000 women among the four tribes, at a rate of ten to twelve women a day.<sup>213</sup> The van will be stationed at each reservation for approximately two weeks at a time and will travel approximately 200-300 days a year, depending on travel time and maintenance and repairs to the van.<sup>214</sup> Satellite service for the van will cost approximately \$10,000 a month.<sup>215</sup>

66. In the foregoing *Report and Order*, we conclude that support for satellite services should be capped at the amount a provider would receive if it received functionally-similar terrestrial-based services.<sup>216</sup> We seek comment on whether it is appropriate to apply this rule to mobile rural health care providers, which by their very nature, are unlikely to be able to utilize terrestrially-based services effectively. In particular, due to the mobile nature of a telemedical unit and the large volume of data it will likely send, would a satellite connection be the most cost-effective method of providing service, even if a terrestrial alternative is available? Should a terrestrial alternative be deemed available and "functionally similar," if by its nature it is tied

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health care providers; (6) the definition of "rural" based on census tracts as outlined by the Economic Research Service of the USDA; (7) the Census Bureau definition of "rural" counties; and (8) any census tract that is not within ten miles of any incorporated or census-designated place containing more than 2,500 people, and is not within a county or county equivalent which has an overall population density of more than 500 persons per square mile of land. See *Facilitating the Provision of Spectrum-Based Services to Rural Areas and Promoting Opportunities for Rural Telephone Companies To Provide Spectrum-Based Services*; 2000 Biennial Regulatory Review, *Spectrum Aggregation Limits for Commercial Mobile Radio Services*; *Increasing Flexibility To Promote Access to and the Efficient and Intensive Use of Spectrum and the Widespread Deployment of Wireless Services, and To Facilitate Capital Formation*, WT Docket Nos. 02-381, 01-14, 03-202, Notice of Proposed Rulemaking, FCC 03-222, paras. 10-12 (rel. Oct. 6, 2003).

<sup>210</sup> Letter to Marlene Dortch, Secretary for the Federal Communications Commission, from Anne Linton, Healthcare Anywhere dated October 21, 2003 (Healthcare Anywhere *Ex Parte*).

<sup>211</sup> *Id.*

<sup>212</sup> *Id.*

<sup>213</sup> *Id.*

<sup>214</sup> *Id.*

<sup>215</sup> *Id.*

<sup>216</sup> See *supra* para. 44.

to a fixed location? We seek comment on how mobile health care providers should make a cost-effective determination for satellite services and whether they should consider the installation and disconnection charges that would be incurred if the mobile rural health clinic were to order a wireline connection at each docking location. Commenters should also discuss whether mobile rural health clinics should be required to service a specific number of locations before satellite services are deemed cost-effective.

67. In the event we conclude that the cap on the provision of support for satellite services where terrestrial service is available should not apply in these circumstances, how should support be provided (*i.e.*, how should discounts be calculated) for satellite services? Commenters are encouraged to discuss whether rural satellite services for mobile rural health clinics should be compared to urban terrestrial services and under what circumstances. We note that two other commenters in this proceeding proposed to provide support for satellite services for mobile health care providers.<sup>217</sup> Commenters should discuss these commenters' proposals. We also ask commenters to estimate the amount of support a mobile rural health clinic would likely receive and the number of mobile units that would likely be eligible. The non-profit entity associated with the tele mammography van states that distance-based charges will not apply to satellite services in the continental United States.<sup>218</sup> We seek comment on whether other similarly situated mobile rural health clinics would be subject to distance-based charges using satellite services and, if so, how the revised MAD would impact support levels.

68. We seek comment on how we should determine whether a mobile health clinic serves rural areas. In particular, should that determination depend on the principal place of business of the provider (such as its mailing address), or should it depend on where the mobile health clinic actually provides service? We also seek comment on whether support for a mobile rural health clinic should be prorated if it also serves non-rural locations.

### C. Administrative Matters

69. In addition, we seek comment on ways to streamline further the application process and expand outreach efforts. In the foregoing *Report and Order*, we note that USAC has implemented many steps to streamline the application process and has increased its outreach efforts, since the *NPRM* was released in 2002.<sup>219</sup> Among other things, USAC has implemented on-line application filing and has arranged for electronic forms to be filled automatically with

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<sup>217</sup> See ATA Comments at 13-14; CTL Comments at 13-14. Specifically, these commenters proposed that the Commission should consider allowing MSV and similar companies, to receive universal service support for mobile satellite services when certain conditions are met: (1) the satellite services are provided only via a mobile unit that will serve a minimum of four rural communities within a State; (2) support would not be provided to a company installing a fixed based unit in an area where terrestrial based services are available, unless they can demonstrate that the rates are equal to the highest tariffed rates of the local exchange carrier; (3) discounts for this service would be calculated the same as discounts for terrestrial based service; (4) the healthcare provider using the mobile service must maintain a detailed log of all network time used, the date it was used and the location from which the mobile service was provided, and submit the logs to USAC within forty-five days of the closing of a funding year. See *id.*

<sup>218</sup> See Healthcare Anywhere *Ex Parte*.

<sup>219</sup> See *supra* para. 54.

the previous year's information for repeat on-line filers. Nevertheless, we seek comment on what additional steps USAC could take to ease further the burdens associated with the application process. For example, what would be the advantages and disadvantages of implementing multi-year applications, so that beneficiaries would not need to apply every funding year? We also seek comment on whether there are additional outreach efforts that USAC could take to inform eligible applicants of the benefits of the program. For instance, should USAC conduct focus groups among rural health care providers to develop ideas on how to identify providers that operate only on a part-time basis? Should USAC contact service providers in rural areas to solicit suggestions for potential eligible users in the area?

## VI. PROCEDURAL MATTERS

### A. Regulatory Flexibility Analysis

70. As required by the Regulatory Flexibility Act, 5 U.S.C. § 604, the Commission has prepared a Final Regulatory Flexibility Analysis (FRFA) for the *Report and Order*, set forth at Appendix C. The Commission has also prepared an Initial Regulatory Flexibility Analysis (IRFA) for the *Further Notice of Proposed Rulemaking (Further Notice)*, set forth at Appendix D. Comments on the FRFA and IRFA should be labeled as IRFA or FRFA Comments, and should be submitted pursuant to the filing dates and procedures set forth in paragraphs 72-79, *infra*.

### B. Paperwork Reduction Act Analysis

71. This *Report and Order*, *Order on Reconsideration*, and *Further Notice of Proposed Rulemaking (Report and Order)* contains either a proposed or modified information collection. As part of the continuing effort to reduce paperwork burdens, we invite the general public and the Office of Management and Budget (OMB) to comment on the information collections contained in this *Report and Order*, as required by the Paperwork Reduction Act of 1995, 44 U.S.C. § 3501 *et seq.* Public and agency comments are due at the same time as other comments on this *Report and Order*; OMB comments are due 60 days from the date of publication of this *Report and Order* in the Federal Register. Comments should address: 1) whether the proposed collection of information is necessary for the proper performance of the functions of the Commission, including whether the information shall have practical utility; 2) the accuracy of the Commission's burden estimates; 3) ways to enhance the quality, utility, and clarity of the information collected; and 4) ways to minimize the burden of the collection of information on the respondents, including the use of automated collection techniques or other forms of information technology.

### C. Filing Procedures

72. Pursuant to sections 1.415 and 1.419 of the Commission's rules,<sup>220</sup> interested parties may file comments not later than 60 days after publication of the *Report and Order* in the Federal Register and may file reply comments not later than 105 days after publication of the *Report and Order* in the Federal Register. In order to facilitate review of comments and reply

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<sup>220</sup> 47 C.F.R. §§ 1.415, 1.419.

comments, parties should include the name of the filing party and the date of the filing on all pleadings. Comments may be filed using the Commission's Electronic Comment Filing System (ECFS) or by filing paper copies.<sup>221</sup>

73. Comments filed through the ECFS can be sent as an electronic file via the Internet to <<http://www.fcc.gov/cgb/ecfs>>. Generally, only one copy of an electronic submission must be filed. If multiple docket or rulemaking numbers appear in the caption of this proceeding, however, commenters must transmit one electronic copy of the comments to each docket or rulemaking number referenced in the caption. In completing the transmittal screen, commenters should include their full name, U.S. Postal Service mailing address, and the applicable docket or rulemaking number. Parties may also submit an electronic comment by Internet e-mail. To get filing instructions for e-mail comments, commenters should send an e-mail to <[ecfs@fcc.gov](mailto:ecfs@fcc.gov)>, and should include the following words in the body of the message, "get form." A sample form and directions will be sent in reply. Or you may obtain a copy of the ASCII Electronic Transmittal Form (FORM-ET) at <[www.fcc.gov/e-file/email.html](http://www.fcc.gov/e-file/email.html)>.

74. Parties that choose to file by paper must file an original and four copies of each filing. Filings can be sent by hand or messenger delivery, by commercial overnight courier, or by first-class or overnight U.S. Postal Service mail (although we continue to experience delays in receiving U.S. Postal Service mail). The Commission's contractor, Natek, Inc., will receive hand-delivered or messenger-delivered paper filings for the Commission's Secretary at a new location in downtown Washington, DC. The address is 236 Massachusetts Avenue, NE, Suite 110, Washington, DC 20002. The filing hours at this location will be 8:00 a.m. to 7:00 p.m. All hand deliveries must be held together with rubber bands or fasteners. Any envelopes must be disposed of before entering the building.

75. Commercial overnight mail (other than U.S. Postal Service Express Mail and Priority Mail) must be sent to 9300 East Hampton Drive, Capitol Heights, MD 20743. U.S. Postal Service first-class mail, Express Mail, and Priority Mail should be addressed to 445 12th Street, SW, Washington, D.C. 20554. All filings must be addressed to the Commission's Secretary, Office of the Secretary, Federal Communications Commission.

| <b>If you are sending this type of document or using this delivery method...</b>   | <b>It should be addressed for delivery to...</b>                                  |
|--|---|
| Hand-delivered or messenger-delivered paper filings for the Commission's Secretary   | 236 Massachusetts Avenue, NE, Suite 110, Washington, DC 20002 (8:00 to 7:00 p.m.) |
| Other messenger-delivered documents, including documents sent by overnight mail (other than United States Postal Service Express Mail and Priority Mail) | 9300 East Hampton Drive, Capitol Heights, MD 20743 (8:00 a.m. to 5:30 p.m.)       |
| United States Postal Service first-class mail, Express Mail, and Priority Mail   | 445 12 <sup>th</sup> Street, SW Washington, DC 20554                              |

<sup>221</sup>See *Electronic Filing of Documents in Rulemaking Proceedings*, 13 FCC Rcd 11322, 11326 (1998).

76. Parties who choose to file by paper should also submit their comments on diskette. These diskettes, plus one paper copy, should be submitted to: Sheryl Todd, Telecommunications Access Policy Division, Wireline Competition Bureau, Federal Communications, at the filing window at 236 Massachusetts Avenue, N.E., Suite 110, Washington, D.C. 20002. Such a submission should be on a 3.5-inch diskette formatted in an IBM compatible format using Word or compatible software. The diskette should be accompanied by a cover letter and should be submitted in "read only" mode. The diskette should be clearly labeled with the commenter's name, proceeding (including the docket number, in this case WC Docket No. 02-60, type of pleading (comment or reply comment), date of submission, and the name of the electronic file on the diskette. The label should also include the following phrase "Disk Copy - Not an Original." Each diskette should contain only one party's pleadings, preferably in a single electronic file. In addition, commenters must send diskette copies to the Commission's copy contractor, Qualex International, Portals II, 445 12th Street, S.W., Room CYB402, Washington, D.C. 20554 (see alternative addresses above for delivery by hand or messenger).

77. Regardless of whether parties choose to file electronically or by paper, parties should also file one copy of any documents filed in this docket with the Commission's copy contractor, Qualex International, Portals II, 445 12th Street S.W., CY-B402, Washington, D.C. 20554 (see alternative addresses above for delivery by hand or messenger) (telephone 202-863-2893; facsimile 202-863-2898) or via e-mail at [qualexint@aol.com](mailto:qualexint@aol.com).

78. Written comments by the public on the proposed and/or modified information collections are due on the same day as comments on the *Report and Order*, i.e., on or before 60 days after publication of the *Report and Order* in the Federal Register. Written comments must be submitted by OMB on the proposed and/or modified information collections on or before 60 days after publication of the *Report and Order* in the Federal Register. In addition to filing comments with the Secretary, a copy of any comments on the information collections contained herein should be submitted to Judith B. Herman, Federal Communications Commission, Room 1-C804, 445 12<sup>th</sup> Street, S.W., Washington, D.C. 20554, or via the Internet to [jbherman@fcc.gov](mailto:jbherman@fcc.gov), and to Jeanette Thornton, OMB Desk Officer, Room 10236 NEOB, 725 17<sup>th</sup> Street, N.W., Washington, D.C. 20503 or via the Internet to [JThornto@omb.eop.gov](mailto:JThornto@omb.eop.gov).

79. The full text of this document is available for public inspection and copying during regular business hours at the FCC Reference Information Center, Portals II, 445 12<sup>th</sup> Street, SW, Room CY-A257, Washington, DC, 20554. This document may also be purchased from the Commission's duplicating contractor, Qualex International, Portals II, 445 12<sup>th</sup> Street, SW, Room CY-B402, Washington, DC, 20554, telephone (202) 863-2893, facsimile (202) 863-2898, or via e-mail [qualexint@aol.com](mailto:qualexint@aol.com).

#### **D. Further Information**

80. Alternative formats (computer diskette, large print, audio recording, and Braille) are available to persons with disabilities by contacting Brian Millin at (202) 418-7426 voice, (202) 418-7365 TTY, or [bmillin@fcc.gov](mailto:bmillin@fcc.gov). This *Report and Order* can also be downloaded in Microsoft Word and ASCII formats at <http://www.fcc.gov/ccb/universalservice/highcost>.

81. For further information, contact Shannon Lipp at (202) 418-7954 or Regina Brown at (202) 418-0792 in the Telecommunications Access Policy Division, Wireline Competition Bureau.

## VII. ORDERING CLAUSES

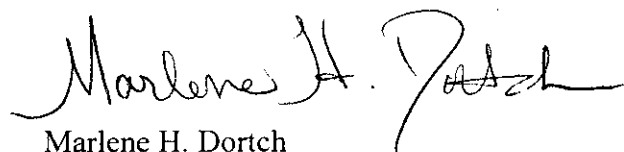
82. Accordingly, IT IS ORDERED that, pursuant to the authority contained in sections 1, 4(i), 4(j), 201-205, 214, 254, and 403 of the Communications Act of 1934, as amended, 47 U.S.C. §§ 151, 154(i), 154(j), 201-205, 214, 254, and 403, this *Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking* IS ADOPTED.

83. IT IS FURTHER ORDERED that, pursuant to the authority contained in section 405, of the Communications Act of 1934, as amended, 47 U.S.C. § 405, and sections 0.291 and 1.429 of the Commission's rules, 47 C.F.R. §§ 0.291 and 1.429, Mobile Satellite Ventures Subsidiary's Petition for Clarification or Reconsideration IS DENIED to the extent indicated herein.

84. IT IS FURTHER ORDERED that Part 54 of the Commission's rules, 47 C.F.R. Part 54, IS AMENDED as set forth in Appendix A attached hereto, effective thirty (30) days after the publication of this *Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking* in the Federal Register.

85. IT IS FURTHER ORDERED that the Commission's Consumer and Governmental Affairs Bureau, Reference Information Center, SHALL SEND a copy of this *Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking*, including the Final Regulatory Flexibility Analysis and Initial Regulatory Flexibility Analysis, to the Chief Counsel for Advocacy of the Small Business Administration.

FEDERAL COMMUNICATIONS COMMISSION



Marlene H. Dortch  
Secretary